EVIDENCE OF COVERAGE

PERSCare

Preferred Provider Organization

Effective
February 1, 2001, through December 31, 2001

Administered by Blue Cross (Blue Cross of California and BC Life & Health Insurance Company) and Merck-Medco Managed Care, L.L.C., for the Board of Administration of the California Public Employees' Retirement System

HOW TO REACH US

CUSTOMER SERVICE

For medical claims status, benefit information, identification cards, booklets, or claim forms, call:

Customer Service Department
Blue Cross of California
1-877-737-7776
1-818-234-5141 (outside the continental U.S.)
1-818-234-3547 (TDD)
Web site: www.bluecrossca.com

Please mail your non-PPO medical claims and correspondence to:

PERSCare Health Plan
Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

Please see page 11 for more information about the BlueCard PPO Network.

UTILIZATION REVIEW SERVICES

To obtain precertification for hospitalizations and specified services, call:

The Review Center
Blue Cross of California
1-800-451-6780
1-818-234-5141 (outside the continental U.S.)

MEDCALL

You can reach a specially trained registered nurse who can address your health care questions by calling MedCall at 1-800-700-9185. Registered nurses are available to answer your medical questions 24 hours a day, seven days a week.

PRESCRIPTION DRUG PROGRAM

For information regarding the Retail Pharmacy Program or Mail Service Program, call:

Merck-Medco Managed Care, L.L.C.
1-800-316-9178
1-972-915-2800 (outside the continental U.S.)
Web site: www.merck-medco.com

ELIGIBILITY AND ENROLLMENT

For information concerning eligibility and enrollment, contact the Health Benefits Officer at your agency (active) or the CalPERS Health Benefit Services Division (retirees). You also may write:

Health Benefit Services Division
CalPERS
P.O. Box 942714
Sacramento, CA 94229-2714

Or call:

1-800-237-3345
(916) 326-3240 (TDD)

ADDRESS CHANGE

Active Employees: To report an address change, active employees should complete and submit the proper form to their employing agency's personnel office.

Retirees: To report an address change, retirees may either call 1-800-352-2238 or submit a signed written notification, including Social Security number, new address, and other pertinent information, to:

CalPERS Benefit Services Division
P.O. Box 942716
Sacramento, CA 94229-2716

PERSCare MEMBERSHIP DEPARTMENT

For direct payment of premiums, contact:

PERSCare Membership Department
Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386
1-877-737-7776
1-818-234-5141 (outside the continental U.S.)

PERSCare WEB SITE

Visit our web site at:

www.calpers.ca.gov/perscare

MedCall

Your Plan includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. When you call MedCall toll free at **1-800-700-9185**, be prepared to provide your name, the patient's name (if you're not calling for yourself), the subscriber's Social Security number, and the patient's phone number.

The nurse will ask you some questions to help determine your health care needs.* Based on the information you provide, the advice may be to:

- Take care of yourself at home. A follow-up phone call may be made to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your physician. If you do not have a physician, the nurse will help you select one by providing a list of physicians who are Preferred Providers in your geographical area.
- Call your physician for further discussion and assessment.
- Go to the emergency room in a Preferred Provider hospital.
- Immediately call 911.

In addition to providing a nurse to help you make decisions about your health care, MedCall gives you free unlimite access to its Audio Health Library, featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll-free 1-800-700-9185 and follow the instructions given.

* Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your physician' care.

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BENEFIT AND ADMINISTRATIVE CHANGES

Notice

Terms and conditions contained in this Evidence of Coverage apply to an 11-month contract period ("plan year") effective February 1, 2001, through December 31, 2001. Please read this booklet carefully.

The following is a brief summary of benefit and administrative changes that will take effect February 1, 2001. Be sure to refer to the Medical and Hospital Benefits section and the Benefit Limitations, Exceptions and Exclusions section for more information.

1. **Plan Year Deductibles and Benefit Maximums.** Deductibles, benefit maximums, and maximum out-of-pocket expenses will be calculated on an 11-month plan year basis, for the period February 1, 2001, through December 31, 2001. Any amount applied to your deductible for services received between January 1, 2001, and January 31, 2001 (under the PERSCare Plan in effect through January 31, 2001) will carry over to the increased deductible in place from February 1, 2001, through December 31, 2001, provided you remain in the PERSCare Plan.

2. **Plan Year Deductible Amount.** The plan year deductible (formerly called "calendar year deductible") will be five hundred dollars ($500) for each Plan Member, not to exceed one thousand dollars ($1,000) per family.

3. **Hospital Admission Deductible.** A two hundred and fifty dollar ($250) deductible will apply to each covered hospital admission.

4. **Emergency Room Deductible.** A fifty dollar ($50) deductible will apply to each covered visit to the emergency room of a hospital.

5. **Physician Office Visit Copayment.** A twenty dollar ($20) copayment is now required for each office visit to a Preferred Provider. The copayment is not subject to the plan year deductible.

6. **Acupuncture.** The Plan now pays ninety (90) percent of the Allowable Amount for acupuncture services if services are received from a Preferred Provider, and pays sixty (60) percent of the Allowable Amount if services are received from a non-Preferred Provider.

7. **Cardiac Rehabilitation.** Precertification by the Review Center is no longer required.

8. **Diabetes Self-Management Education Program.** The Plan has been revised to provide coverage for diabetes education program services in accordance with the same terms and conditions that apply to medical office visits to a Physician.

9. **Home Infusion Therapy.** New language clarifies that home infusion therapy is covered only if the services are determined by the Review Center to be medically necessary and appropriate, and if the Member is homebound.

10. **Mental Health Benefits.** New language clarifies that non-therapeutic treatment, custodial care, and educational programs are not covered.

11. **Pulmonary Rehabilitation.** Precertification by the Review Center is no longer required.

12. **Skilled Nursing Facility.** The Plan now pays sixty (60) percent of the Allowable Amount for each day of a covered stay if services are received from a non-Preferred Provider.

13. Speech Therapy. The Plan now pays ninety (90) percent of the Allowable Amount for covered speech therapy services received from a Preferred Provider, and pays sixty (60) percent of the Allowable Amount if services are received from a non-Preferred Provider. The Member's copayment applies toward the maximum plan year copayment responsibility if services are received from a Preferred Provider; however, the maximum copayment is unlimited if services are received from a non-Preferred Provider.

14. Outpatient Prescription Drug Program:

- **Incentive Formulary.** The list of formulary medications has not changed. However, the Plan has moved to an incentive-based program, where higher copayments will apply to certain covered drug categories.
- **Prescriptions Drug Copayments.**

  Retail Program:

Generic	$5
Formulary brand-name	$15
Non-formulary brand-name	$30

  Mail Service Program:

Generic	$10
Formulary brand-name	$25
Non-formulary brand-name	$45

- **Managed Prior Authorization Program.** The list of prescription drugs that require prior authorization by Merck-Medco Managed Care, L.L.C., has been updated (see page 44).
- **Managed Rx Coverage Program.** Language has been added to describe Merck-Medco's Managed Rx Coverage Program (see page 43).
- **Mail Service Program.** A one thousand dollar ($1,000) maximum plan year copayment (per person) now applies for mail order prescriptions.
- **Injectable Contraceptives.** Injectable contraceptives (e.g., Depo-Provera) are now covered.

PERSCare SUMMARY OF BENEFITS

The following chart is only a summary of benefits under your PERSCare Plan. Please refer to the Medical and Hospital Benefits section beginning on page 23 for specific information and limitations. It will be to your benefit to familiarize yourself with the rest of this booklet before you need services so that you will understand the Plan's and your responsibilities for meeting Plan requirements. Deductibles and copayments applied to any other CalPERS-sponsored health plan will not apply to PERSCare and vice versa. **Lack of knowledge of, or lack of familiarity with, this information does not serve as an excuse for noncompliance.**

Plan Year Deductible

For each Plan Member.....**$500**

For each family.....**$1,000**

(The Plan Year begins February 1, 2001 and ends December 31, 2001. See page 15 for services not subject to the deductible.)

Hospital Admission Deductible.....**$250 per admission**

Emergency Room Deductible.....**$50 per visit**
(Deductible does not apply if you are admitted to a hospital on an inpatient basis immediately following emergency room treatment.)

Maximum Copayment Responsibility for PPO Provider Services

For each Plan Member.....**$2,000**

For each family **$4,000**

(Non-PPO provider copayments are not applied toward this amount and are the Member's responsibility. See page 16 for more information.)

Benefits	Covered Services	Member Pays		Contact Review Center
		PPO	Non-PPO	
Hospital Inpatient p. 30	Room and board, general nursing care services, operating and special care room fees, diagnostic X-ray and laboratory services. Note: A $250 hospital admission deductible applies for each admission.	10%	40%	Yes
Outpatient p. 31	Diagnostic, therapeutic and surgical services, including radiation therapy, chemotherapy treatments and kidney dialysis.	10%	40%	No (unless listed on page 41)
Ambulatory Surgery Center p. 24	Services in connection with outpatient surgery.	10%	40%	No (unless listed on page 41)
Physician Services p. 34	Office visits and outpatient hospital visits.	$20 copay	40%	No
Preventive Care p. 35	Immunizations and periodic health exams.	No Charge	40%	No
Diagnostic X-ray/Laboratory p. 26	Outpatient diagnostic X-ray and laboratory services, including Pap tests and mammograms for treatment of illness.	10%	40%	No
	MRIs of the spine.	10%	40%	Yes
Hearing Aid Services p. 28	Audiological evaluation and hearing aid supplies; visits for fitting, counseling, adjustment, and repair. Up to $1,000 once every 36 months for the hearing aid(s).	10%	40%	No
Maternity p. 31	Prenatal and postnatal care; deliveries, hospitalization and newborn nursery care. Note: A $250 hospital admission deductible applies for each admission.	10%	40%	No

Benefits	Covered Services	Member Pays		Contact Review Center
		PPO	Non-PPO	
Family Planning p. 28	Services for voluntary sterilization and medically necessary abortions.	10%	40%	No
Natural Childbirth Classes p. 33	Lamaze classes given by licensed instructors certified by ASPO/Lamaze Childbirth Educators.	Plan pays 50% of registration fee up to $50, whichever is less.		No
Ambulance p. 23	Air or ground ambulance services when medically necessary.	20%	20%	No
Emergency Care Services p. 27	Services required for the alleviation of the sudden onset of severe pain or unforeseen illness or injury which could lead to further significant disability or death, or which would so appear to a prudent layperson. Note: Emergency room facility charges for non-emergency care services are the Plan Member's responsibility. A $50 emergency room deductible applies for covered emergency room charges unless admitted to the hospital. If admitted to the hospital, the $50 emergency room deductible is waived, and the $250 hospital admission deductible applies.	10%	10%	Yes (Hospital Admissions only)
Mental Health Inpatient p. 31	Hospital/physician services to stabilize an acute psychiatric condition, up to 30 days per plan year. Note: A $250 hospital admission deductible applies for each admission.	10%	40%	Yes
Outpatient p. 32	Medically necessary treatment to stabilize an acute psychiatric condition, up to 30 precertified visits per plan year.	10%	40%	Yes
Chemical Dependency	$12,000 lifetime maximum payment for any combination of inpatient and outpatient services.			
Inpatient p. 24	Hospital/physician services for short-term (3 to 5 days) medical management of detoxification or withdrawal symptoms, up to 15 days per plan year. Note: A $250 hospital admission deductible applies for each admission.	10%	40%	Yes
Outpatient p. 25	Medically necessary treatment to stabilize an acute chemical dependency condition, up to 30 visits per plan year.	10%	40%	Yes
Home Health Care p. 28	Medically necessary skilled care, not custodial care, furnished by a Home Health Agency or Visiting Nurse Association, up to 100 visits per plan year.	10%	40%	Yes

Benefits	Covered Services	Member Pays PPO	Member Pays Non-PPO	Contact Review Center
Home Infusion Therapy p. 29	Pharmaceuticals and medical supplies.	10%	40%	Yes
	Skilled nursing visits in association with home infusion (provided under the Home Health Care benefit).	10%	40%	Yes
Skilled Nursing Facility p. 36	Medically necessary skilled care, not custodial care, in a skilled nursing facility, up to 180 days per plan year.	10% for 1st 10 days 20% next 170 days	40% 40%	Yes Yes
Therapies				
Speech p. 33	Services provided by a qualified speech therapist for an acute condition; $5,000 lifetime maximum.	10%	40%	No
Physical p. 34	Services provided by a licensed physical therapist for an acute condition. Services provided in the home are covered under the Home Health Care benefit.	10%	40%	No
Occupational p. 34	Services provided by a licensed occupational therapist for an acute condition. Services provided in the home are covered under the Home Health Care benefit.	20%	20%	No
Acupuncture p. 25	Services provided by a certified acupuncturist.	10%	40%	No
Chiropractic p. 25	Services provided by a licensed chiropractor. *Benefits are limited to 20 visits per plan year for any combination of chiropractic and acupuncture services.*	10%	40%	No
Durable Medical Equipment p. 26	Rental or purchase of durable medical equipment.	10%	40%	No
Other Benefits	Unreplaced blood	20%	20%	No
	Reconstructive surgery — see page 35.	10%	40%	Yes
	TMD and Maxillomandibular Musculoskeletal Treatment — see page 36.	10%	40%	Yes
	Transplant Benefits			
	Kidney, Cornea, and Skin — see page 38.	10%	40%	Yes
	Special Transplants only at Blue Cross Centers of Expertise — see page 38.	10%	10%	Yes
	Hospice Care — $10,000 lifetime maximum. See page 30.	10%	10%	Yes
	Outpatient Cardiac Rehabilitation — up to 30 visits per plan year. See page 34.	10%	40%	No
	Outpatient Pulmonary Rehabilitation — up to 30 visits per plan year. See page 34.	10%	40%	No
	Christian Science Treatment — see page 25.	20%	20%	No

Benefits	Covered Services	Member Pays
Prescription Drugs	**Retail Pharmacy Program** (PAID Prescriptions) — Outpatient prescription drugs; insulin; glucose test strips; birth control pills. **Mail Service Program** (Merck-Medco Rx Services) — Maintenance medications; extended supply for vacations. A $1,000 maximum copayment per person per plan year applies.	$5 generic $15 formulary brand-name $30 non-formulary brand-name 34-day supply $10 generic $25 formulary brand-name $45 non-formulary brand-name 90-day supply

INTRODUCTION

Welcome to PERSCare!

As a Preferred Provider Organization (PPO) plan, PERSCare allows you to manage your health care through the selection of physicians, hospitals, and other specialists who you determine will best meet your needs. By becoming familiar with your coverage and using it carefully, you will become a wise health care consumer. Blue Cross and Merck-Medco Managed Care, L.L.C., are the administrative service organizations for the Plan.

Blue Cross establishes medical policy for PERSCare, processes medical claims, and provides the Preferred Provider Network of physicians, hospitals, and other health care professionals and facilities. In California, providers participating in the Preferred Provider Network are referred to as "Prudent Buyer Plan Providers." Blue Cross of California also has a relationship with the Blue Cross and Blue Shield Association, which allows you to access the nationwide BlueCard Preferred Provider Network under this Plan.

Blue Cross' Review Center provides utilization review of hospitalizations, specified services, and outpatient surgeries to ensure that services are medically necessary and efficiently delivered.

MedCall provides a toll-free phone line, where registered nurses are available to answer your medical questions 24 hours a day, seven days a week.

Merck-Medco Managed Care, L.L.C., provides outpatient prescription medication through its subsidiaries PAID Prescriptions, L.L.C., and Merck-Medco Rx Services.

Please take the time to familiarize yourself with this booklet. As a PERSCare Member, you are responsible for meeting the requirements of the Plan. **Lack of knowledge of, or lack of familiarity with, the information contained in this booklet does not serve as an excuse for noncompliance.**

Thank you for joining PERSCare!

HOW TO USE THE PLAN

PERSCare Identification Card

Following enrollment in PERSCare, you will receive a PERSCare ID card. Simply present this card to receive medical services and prescription drug benefits of the Plan. If you need a replacement card or a card for a family member, call the Blue Cross Customer Service Department at 1-877-737-7776.

Possession of a PERSCare ID card confers no right to services or other benefits of this Plan. To be entitled to services or benefits, the holder of the card must, in fact, be a Plan Member on whose behalf premiums have actually been paid, and the services and benefits must actually be covered and/or preauthorized as appropriate.

If you allow the use of your ID card (whether intentionally or negligently) by an unauthorized individual, you will be responsible for all charges incurred for services received. Any other person receiving services or other benefits to which he or she is not entitled, without your consent or knowledge, is responsible for all charges incurred for such services or benefits.

Benefits of this Plan are available only for services and supplies furnished during the term the Plan is in effect and while the benefits you are claiming are actually covered by this Plan.

If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to services or supplies furnished on or after the effective date of modification. There is no vested right to receive the benefits of this Plan.

Choosing A Physician/Hospital

Your copayment responsibility will be lower and claims submission easier if you choose Preferred Providers for your health care. (For more information, see Maximum Plan Year Copayment Responsibility on page 16, and Payment and Member Copayment Responsibility on page 17.) To receive the highest level of benefits available under this Plan, make sure the providers you are using are Preferred Providers.

In California

The Preferred Provider Network available to PERSCare Members in California is called the Prudent Buyer Plan Network. Blue Cross has contracted with three out of four eligible doctors in California to participate in the Prudent Buyer Plan Network. This extensive network includes over 44,990 physicians, 435 hospitals, and over 310 ambulatory surgery centers, in addition to many other types of providers.

To make sure you are using a Prudent Buyer Plan Provider, you may:

--Call Customer Service at 1-877-737-7776 to verify that the provider you want to use is a Prudent Buyer Plan Provider.

--Ask your physician or provider if he or she is a Prudent Buyer Plan Provider (many providers display signs in their lobbies indicating that they are Blue Cross Prudent Buyer Plan Providers).

--Access the Web site at www.bluecrossca.com.

--Request a Prudent Buyer Plan Directory by calling 1-877-737-7776.

Outside California

Blue Cross of California has a relationship with the Blue Cross and Blue Shield Association which allows them to provide claims processing and the use of the BlueCard Preferred Provider Network under this Plan. The BlueCard Program allows PERSCare Members who live or are traveling outside California to use Blue Cross and/or Blue Shield plan providers throughout the United States. (For more information, see Understanding BlueCard on page 11.)

Through the BlueCard Program, you have access to more than 550,000 physicians and over 61,000 hospitals participating in the Blue Cross and/or Blue Shield network of Preferred Providers.

To locate a Blue Cross or Blue Shield Plan PPO provider, you may:

--Call the BlueCard Access Line at 1-800-810-BLUE (1-800-810-2583).

--Ask your physician or provider if he or she participates in the local Blue Cross/Blue Shield plan.

--Access the Web site at www.bluecares.com/bluecard.

--Request a Preferred Provider Directory by calling 1-877-PERS-PPO (1-877-737-7776).

Changes frequently occur after the directories are published; therefore, it is your responsibility to verify that the provider you choose is still a Preferred Provider and that any providers you are referred to are also Preferred Providers.

Service Areas

PERSCare has established geographic service areas to determine the percentage of reimbursement for covered medical and hospital services. The benefits available through PERSCare depend on whether you and your family use Preferred Providers, except for emergencies. Reimbursement for covered services also depends on whether you are in-area or out-of-area.

If you must travel more than fifty (50) miles from your home to the nearest Blue Cross of California Prudent Buyer Plan provider or local Blue Cross/Blue Shield plan provider, you are considered to be outside the PERSCare service area. Out-of-area medical and hospital services, including services received in a foreign country, are reimbursed at the Preferred Provider (PPO) level, based on Blue Cross of California's Allowable Amounts.

If your address of record indicates that you reside within the PERSCare service area (in-area) but you choose to receive services out-of-area, benefits will be reimbursed at the non-Preferred Provider level if services are received from a non-Preferred Provider.

In California

Using the above criteria, the following California ZIP Codes will be considered "out-of-area" for reimbursement of covered medical and hospital services.

COUNTIES	ZIP CODES
Humboldt	95556
Inyo	92328, 92384, 92389, 93513 93514, 93515, 93522, 93526 93530, 93545, 93549
Mono	93512, 93517, 93529, 93541 93546, 96107, 96133
Riverside	92239
San Bernardino	92242, 92267, 92280, 92309 92319, 92323, 92332, 92364 92366, 93562
Siskiyou	95568, 96023, 96039, 96058 96086, 96134

Outside California

Although there are Preferred Providers available in 53 Blue Cross/Blue Shield plans across the country, there are a few areas in the United States that do not have PPO providers located within a PERSCare service area. Members in those areas shall be considered "out-of-area." Covered services for out-of-area Members will be reimbursed at the higher Preferred Provider level of benefits.

To find out if you are considered out-of-area, please call Customer Service at 1-877-737-7776.

Outside the United States

For Medical Claims: The benefits of this Plan are provided anywhere in the world. With the exception of services provided by a hospital participating in the BlueCard Worldwide Network (see page 12), if you are traveling or reside in a foreign country and need medical care, you may have to pay the bill and then be reimbursed. You should ask the provider for an itemized bill (written in English). The bill must then be submitted directly to Blue Cross at P.O. Box 4386, Woodland Hills, CA 91365-4386. Members traveling or residing outside the United States shall be considered "out-of-area." Covered services for these Members will be reimbursed at the higher Preferred Provider level of benefits.

For Prescription Drug Claims: There are no participating pharmacies outside of the United States. To receive reimbursement for outpatient prescription drugs purchased outside the United States, complete a Direct Reimbursement Claim form and mail it to PAID Prescriptions, L.L.C., at P.O. Box 1030, Parsippany, NJ 07054-1030 (or mail it to the address listed on the back of the claim form). Prescription medication covered by the Plan will be reimbursed at one hundred percent (100%), minus a thirty dollar ($30) copayment for a 1-month supply, based on the foreign exchange rate on the date the claim is processed. **Claims must be submitted within twelve (12) months from the date of service.**

HOW TO USE THE PLAN

Understanding BlueCard

What Is BlueCard?

BlueCard is a national PPO program that allows PERSCare Basic Plan Members access to Blue Cross/Blue Shield Preferred Providers in 53 Blue Cross/Blue Shield Plans across the country. The BlueCard Program is offered by the national Blue Cross and Blue Shield Association, of which Blue Cross of California is a Member.

Who Has BlueCard Preferred Provider Access?

All Members with PERSCare Basic Plan coverage have BlueCard Preferred Provider access. BlueCard Preferred Providers will identify you as a BlueCard Member by the small black suitcase logo containing the letters "PPO" on the front of your ID card. (The suitcase logo does not appear on Alabama Members' ID cards due to state restrictions.)

When May I Access BlueCard Preferred Providers?

Members may access BlueCard Preferred Providers anytime. California Members may use BlueCard providers when needing services outside of California. Out-of-state Members may use BlueCard providers when needing services outside of the state or service area covered by their local Blue Cross/Blue Shield plan.

How Do I Use BlueCard?

Call 1-800-810-BLUE (1-800-810-2583) for referral to a BlueCard Preferred Provider or to inquire whether the physician or facility you are planning to use is a BlueCard Preferred Provider, or visit the BlueCard Web site at www.bluecares.com/bluecard. You may also obtain a provider directory by calling Blue Cross of California at 1-877-PERS-PPO (1-877-737-7776). When you present your PERSCare ID card to a BlueCard Preferred Provider, the provider verifies your membership and coverage by calling the Customer Service number printed on the front of your ID card.

How Does BlueCard Claim Filing Work?

The BlueCard provider will file your claim with the local Blue Cross/Blue Shield plan. The local Blue Cross/Blue Shield plan transmits the claim electronically to Blue Cross of California. Blue Cross of California applies PERSCare benefits, electronically transmits the approved payment amount back to the provider's local Blue Cross/Blue Shield plan, and then sends you an Explanation of Benefits (EOB). The local plan sends payment and an EOB to the provider.

What If I Use Out-of-Network Providers?

Benefits are paid at the non-Preferred Provider reimbursement level unless:

- You require emergency care services.
- There are no Preferred Providers available. Call 1-800-810-BLUE (1-800-810-2583) to verify whether there are any Preferred Providers available to you BEFORE you receive services.
- You live outside California and are considered an "out-of-area" Member.

Members and/or out-of-network providers must submit claims for services delivered by out-of-network providers directly to Blue Cross of California, using a claim form.

For more information, please see the Payment and Member Copayment Responsibility section, beginning on page 17.

HOW TO USE THE PLAN

What Is BlueCard Worldwide And How Does It Work?

The BlueCard Worldwide Network comprises Blue Cross/Blue Shield participating hospitals in major international travel destinations. The BlueCard Worldwide network is available for medical care requiring an overnight stay in a hospital. When you need hospital care outside the United States, simply present your PERSCare ID card at a participating hospital. The hospital submits any claims to Blue Cross of California and will charge you only the appropriate copayment or deductible amounts. You may obtain a brochure containing further information, including how to locate participating hospitals, by calling the Customer Service telephone number printed on the front of your ID card. You may also call 1-800-810-BLUE (1-800-810-2583) or access the BlueCard Web site at www.bluecares.com/bluecard to locate a participating hospital.

Accessing Services

If you need emergency care, call your physician or go to the nearest facility that can provide emergency care. Present your PERSCare ID card and make sure that you, a family member, or a friend contact the Review Center at 1-800-451-6780 within twenty-four (24) hours or by the end of the first business day following admission, whichever is later. Failure to notify the Review Center within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Before receiving non-emergency services, be sure to discuss the services and treatment thoroughly with your physician and other provider(s) to ensure that you understand the services you are going to receive. Then refer to the Medical and Hospital Benefits section beginning on page 23 and the Benefit Limitations, Exceptions and Exclusions section beginning on page 51 to make sure the proposed services are covered benefits of this Plan. If you are still not sure whether the recommended services are benefits of this Plan, please refer to the inside front cover of this booklet for the appropriate number to call for assistance.

If precertification by the Review Center is required, please refer to pages 40 through 42 and remember to call the Review Center before services are provided to avoid increased copayment responsibility on your part. **Do not assume the Review Center has been contacted — confirm with the Review Center yourself.**

Utilization Review

Utilization review is designed to involve you in an educational process that evaluates whether health care services are medically necessary, provided in the most appropriate setting, and consistent with acceptable treatment patterns found in established managed care environments. Blue Cross of California's Review Center reviews inpatient hospitalizations, including emergencies but excluding maternity admissions under a 48-hour stay for a normal delivery or a 96-hour stay for a Cesarean delivery and admissions for mastectomy or lymph node dissection. The Review Center also reviews certain medical services and outpatient surgical procedures.

Contacting the Review Center when necessary, before receiving services, and complying with the Review Center's recommendations can help you receive maximum benefit coverage and thus minimize your out-of-pocket costs. The Review Center may monitor your care during treatment and throughout a hospitalization to help ensure that quality medical care is efficiently delivered.

Services which are determined by the Review Center not to be medically necessary or efficiently delivered may not be covered under the Plan. Failure to obtain precertification from the Review Center within the specified time frame may result in increasing your copayment responsibility by the application of financial sanctions or denial of payment.

Refer to pages 40 through 42 for more information on utilization review procedures, and to page 22 for more information on financial sanctions.

HOW TO USE THE PLAN

Outpatient Prescription Drug Program

Outpatient prescription drugs prescribed in connection with a covered illness or accidental injury and dispensed by a registered pharmacist may be obtained either through the Retail Pharmacy Program (PAID Prescriptions, L.L.C.) or the Mail Service Program (Merck-Medco Rx Services).

Your copayment will vary based on which program you use, whether you use generic or brand-name drugs, and whether your brand-name drug is on the Preferred Prescriptions Formulary. To find out if your medication is on the Preferred Prescriptions Formulary, call Merck-Medco Member Services at 1-800-316-9178, or visit the Web site at www.merckmedco.com.

The Outpatient Prescription Drug Program also provides educational materials and counseling services to those aged 65 or older. As part of the "Partners For Healthy Aging Program," Members receive a formulary "pocket guide" and a Health Assessment Questionnaire. Both of these components have been designed specifically for seniors. Participation, although voluntary, is strongly encouraged.

Refer to pages 46 and 47 for information on the Retail Pharmacy Program and to pages 47 and 48 for information on the Mail Service Program. Page 46 contains information on how to file a claim. For the name of a Participating Pharmacy close to you, call PAID Prescriptions at **1-800-316-9178** or visit the Web site at www.merckmedco.com.

Medical Services

When you need health care, simply present your PERSCare ID card to your physician, hospital, or other licensed health care provider. Remember, your copayment responsibility will be lower if you choose a Preferred Provider.

Refer to page 57 for information on filing a medical claim.

Appeals

If you disagree with the processing of or the decision made on your claim and you wish to contest the decision, you must appeal through the appropriate third-party administrator (Blue Cross or Merck-Medco) first. If you wish to pursue the matter after exhaustion of the third-party administrator's appeal procedures, you may request a final administrative determination from CalPERS within thirty (30) days of the appropriate third-party administrator's final decision. For detailed information, see CalPERS Final Administrative Determination Procedure on page 74.

Payment to Providers—Assignment of Benefits

The benefits of this Plan will be paid directly to Preferred Providers and medical transportation providers. Also, Non-Preferred Providers and other providers of service will be paid directly when you assign benefits in writing.

MEDICAL NECESSITY

Except for preventive care services, benefits are provided only for covered services, procedures, equipment and supplies which are medically necessary and delivered with optimum efficiency.

Medical necessity means services and supplies as determined through the Plan's review process to be necessary, appropriate, and established as safe and effective for treatment of the patient's illness or injury consistent with acceptable treatment patterns found in established managed care environments and consistent with Blue Cross' Medical Policy. **The fact that a provider may prescribe, order, recommend or approve a service, supply, or hospitalization does not in itself make it medically necessary, even though it is not specifically listed as an exclusion or limitation.** A service may be determined not to be medically necessary even though it may be considered beneficial to the patient. Established medical criteria for medical necessity must be met before that service, procedure, equipment or supply is determined to be medically necessary.

Services, procedures, equipment and supplies that are medically necessary must:

1. be appropriate and necessary for the diagnosis or treatment of the medical condition;
2. be consistent with the symptoms or diagnosis in treatment of the illness, injury, or condition;
3. be within standards of good medical practice within the organized medical community;
4. not be furnished primarily for the convenience of the patient, the treating physician, or other provider;
5. be consistent with Blue Cross' Medical Policy;
6. not be for custodial care (see definition on page 79); and
7. be the most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements;
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received in an outpatient setting or in a less intensified medical setting.

Inpatient hospital services or supplies which are generally not considered medically necessary include, but are not limited to, hospitalization:

1. for diagnostic studies that could have been provided on an outpatient basis;
2. for medical observation or evaluation;
3. to remove the patient from his or her customary work and/or home for rest, relaxation, personal comfort, or environmental change;
4. for preoperative work-up the night before surgery;
5. for inpatient rehabilitation or rehabilitative care that can be provided on an outpatient basis.

Outpatient services may not always be considered medically necessary.

Claims Review

PERSCare reserves the right to review all claims and medical records to determine whether services, procedures, equipment and supplies are medically necessary and efficiently delivered, and whether any exclusions or limitations apply.

DEDUCTIBLES

Plan Year Deductible

Charges incurred while covered by any other CalPERS-sponsored health benefits plan for services received prior to the effective date of enrollment in PERSCare are not transferable to PERSCare, and deductibles under any other such plan will not apply toward the plan year deductible for PERSCare.

After the plan year deductible and any other applicable deductible is satisfied, payment will be provided for covered services. Many services, however, are not subject to the deductible (see the list below).The deductible must be made up of charges covered by the Plan in the plan year in which the services are provided. The plan year deductible applies separately to each Plan Member and is accumulated in the order in which claims processing has been completed.

The plan year deductible is five hundred dollars **($500)** for each Plan Member, not to exceed one thousand dollars **($1,000)** per family.

Charges will be applied to the deductible beginning on February 1, 2001, and will extend through December 31, 2001. In addition, any amount applied to your deductible for services received between January 1, 2001 and January 31, 2001 (under the PERSCare Plan in effect from January 1, 2000 through January 31, 2001) will be applied toward the plan year deductible shown above.

Services NOT subject to the plan year deductible:

--Physician office/outpatient hospital visits and consultations received from Preferred Providers.

--Diabetes self-management education program services received from Preferred Providers.

--Inpatient hospital facility charges, including alternative birthing centers. However, the deductible will apply to inpatient hospital facility charges for the treatment of mental health and chemical dependency.

--Immunizations received from Preferred Providers.

--Preventive care services received from Preferred Providers.

--Natural childbirth classes.

NOTE: Other services received in conjunction with any of the services listed above ARE subject to the deductible. Also, services listed above received from non-Preferred Providers ARE subject to the deductible.

Hospital Admission Deductible

Each time you are admitted to a hospital on an inpatient basis, you are responsible for paying a two hundred and fifty dollar **($250)** hospital admission deductible.

Emergency Room Deductible

Each time you visit a hospital's emergency room you will be responsible for paying the emergency room deductible. However, this deductible will not apply if you are admitted to a hospital on an inpatient basis from the emergency room immediately following emergency room treatment. This deductible will be subtracted from covered charges remaining after your plan year deductible has been satisfied.

MAXIMUM PLAN YEAR COPAYMENT RESPONSIBILITY

When covered services are received from a Preferred Provider, or if you live and receive covered services outside a Preferred Provider area, your maximum copayment responsibility per plan year is two thousand dollars ($2,000) per Plan Member, not to exceed four thousand dollars ($4,000) per family. Once you incur expenses equal to those amounts, you will no longer be required to pay a copayment for the remainder of that year, but you remain responsible for costs in excess of the Allowable Amount and for services or supplies which are not covered under this Plan.

Covered services received from non-Preferred Providers, whether referred by a Preferred Provider or not, do not apply toward the maximum copayment if you live within a Preferred Provider area.* In addition, you will be required to continue to pay your copayment for such treatment even after you have reached that amount. Remember, your copayment will be higher if you use non-Preferred Providers, and you will be responsible for any charges that exceed the Allowable Amount.

*Exceptions:

-- Covered services received from non-Preferred Providers will apply toward the maximum copayment amount if (1) you are unable to access a Preferred Provider who practices the appropriate specialty, provides the required services or has the necessary facilities within a 50-mile radius of your residence and you obtain an Authorized Referral, or (2) your claim is reprocessed to provide benefits at the higher Preferred Provider reimbursement level. Once the maximum copayment responsibility is met, you will no longer be required to pay a copayment for such non-Preferred Provider services, but you remain responsible for costs in excess of the Allowable Amount and for services or supplies which are not covered under this Plan.

-- Emergency care services provided by non-Preferred Providers will apply toward the maximum copayment amount. Once the maximum copayment responsibility is met, you will no longer be required to pay a copayment for such non-Preferred Provider services, but you remain responsible for costs in excess of the Allowable Amount and for services or supplies which are not covered under this Plan.

The following are not included in calculating your maximum plan year copayment. You will continue to be responsible for these charges even after you have reached the maximum plan year copayment amount:

--Copayments to Preferred Providers for physician office/outpatient hospital visits, consultations, and diabetes self-management education program services.

--Copayments to non-Preferred Providers if you live within a Preferred Provider area.

--Copayments for treatment of mental health and chemical dependency.

--Copayments for natural childbirth classes.

--All charges not paid by the Plan for outpatient prescription drugs.

--Sanctions for non-compliance with utilization review.

--Amounts applied toward the plan year deductible, the emergency room deductible, or the hospital admission deductible.

--Charges for services which are not covered.

--Charges in excess of stated benefit maximums.

--Charges by non-Preferred Providers in excess of the Allowable Amount.

PAYMENT AND MEMBER COPAYMENT RESPONSIBILITY

(Not applicable to the Prescription Drug Program)

Preferred Providers within their geographic service area have agreed to accept Blue Cross of California's payment or the local Blue Cross/Blue Shield plan's payment, whichever is applicable, plus applicable Member deductibles and copayments, as payment in full for covered services. Except for applicable deductibles, copayments or amounts in excess of specified Plan maximums, Plan Members are not responsible to Preferred Providers for any additional payments for covered services.

Non-Preferred Providers are providers which have not agreed to participate in Blue Cross of California's Prudent Buyer Plan network (within California) or in a Blue Cross and/or Blue Shield plan network (outside of California). They have not agreed to accept Blue Cross of California's payment or the local Blue Cross/Blue Shield plan's payment (plus applicable Member deductibles and copayments) as payment in full for covered services. The amount that will be considered the Allowable Amount for services received by Non-Preferred Providers is usually lower than what they customarily charge. The difference between the Allowable Amount and what the Non-Preferred Provider charges is the Member's responsibility.

The following example illustrates the Member's reduced out-of-pocket amount when receiving services from a Preferred Provider:

Payment Example
(Actual Charges May Vary)
Procedure: Removal of a ruptured spinal disc

Preferred Provider

Billed Charges (physician surgical fees and hospital charges)	$12,000
Plan(s) Allowable Amount	$ 6,000
Plan Pays 90% of $6,000	$ 5,400
You Pay 10% of $6,000	**$ 600**
Preferred Provider Cannot Balance Bill	$ 6,000

Non-Preferred Provider

Billed Charges (physician surgical fees and hospital charges)	$12,000
Plan(s) Allowable Amount	$ 6,000
Plan Pays 60% of $6,000	$ 3,600
You Pay 40% of $6,000	**$ 2,400**
Plus Balance Billed by Provider	**$ 6,000**
Total You Pay	**$ 8,400**

PAYMENT AND MEMBER COPAYMENT RESPONSIBILITY

After the plan year and any other applicable deductible has been satisfied, reimbursement for covered services will be provided as described in this section.

Physician Services

1. Members Who Reside Within Area

a. When Accessing Preferred Providers:

Physician office visits and physician outpatient hospital visits by a Preferred Provider are paid at Blue Cross' Allowable Amount or the local Blue Cross/Blue Shield plan's Allowable Amount less the Member's twenty dollar ($20) copayment. The twenty dollar ($20) copayment will also apply to physician or health professional visits for diabetes self-management education. The twenty dollar ($20) copayment does not apply to physician visits related to mental health or chemical dependency.

Covered services rendered by a Preferred Provider are paid at ninety percent (90%) of the Allowable Amount, except for services with a twenty dollar ($20) copayment. Plan Members are responsible for the remaining ten percent (10%) and any charges for non-covered services if rendered by a Preferred Provider. Preventive care services received from a Preferred Provider are paid at one hundred percent (100%) of the Allowable Amount.

Non-Preferred Provider visits will be paid at the non-Preferred Provider level as stated in (b).

NOTE: Members who reside within a Preferred Provider service area and receive services from a non-Preferred Provider will be reimbursed at the non-Preferred Provider level as stated in (b).

b. When Accessing Non-Preferred Providers:

Covered services rendered by a non-Preferred Provider are paid at sixty percent (60%) of the Allowable Amount. Plan Members are responsible for the remaining forty percent (40%) and all charges in excess of the Allowable Amount, plus all charges for non-covered services.

NOTE: Regardless of the reason (medical or otherwise), referrals by Preferred Providers to non-Preferred Providers will be reimbursed at the non-Preferred Provider level.

c. When Accessing a Non-Preferred Provider Because a Preferred Provider is not Available:

Covered services rendered by a non-Preferred Provider (other than for emergency care services) are automatically paid at sixty percent (60%) of the Allowable Amount. However, if you receive covered services from a non-Preferred Provider because a Preferred Provider is not available within a 50-mile radius of your residence, your claim will automatically be paid at ninety percent (90%) of the Allowable Amount if an Authorized Referral is obtained prior to services being rendered.

If an Authorized Referral is NOT obtained prior to services being rendered, your claim will automatically be paid at sixty percent (60%) of the Allowable Amount. Upon receipt of your Explanation of Benefits (EOB), contact your Customer Service Department to request that your claim be reprocessed at the ninety percent (90%) level. You are responsible for the remaining ten percent (10%) and any charges in excess of the Allowable Amount, plus all charges for non-covered services.

PAYMENT AND MEMBER COPAYMENT RESPONSIBILITY

To ensure that your claims will be paid at the ninety percent (90%) level, you should obtain an Authorized Referral BEFORE services are rendered. To obtain an Authorized Referral, you or your physician must call the Customer Service Department at the toll-free telephone number printed on your ID card at least three (3) business days prior to scheduling an admission to, or receiving the services of, a non-Preferred Provider. If the service you will receive from a non-Preferred Provider requires precertification, you will need to obtain precertification in addition to the Authorized Referral.

These provisions apply to Members residing inside or outside California, unless such Member's residence is considered to be "out-of-area."

2. Members Who Reside Out-of-Area
(Refer to the list of qualifying ZIP Codes and Outside California information on page 10)

Physician office visits and physician outpatient hospital visits are paid at the Allowable Amount less the Member's twenty dollar ($20) copayment. Members are responsible for the twenty dollar ($20) copayment, any charges in excess of the Allowable Amount, and all non-covered charges. The twenty dollar ($20) copayment will also apply to physician or health professional visits for diabetes self-management education. The twenty dollar ($20) copayment does not apply to physician visits related to mental health or chemical dependency.

Other covered services are paid at ninety percent (90%) of the Allowable Amount. Members are responsible for the remaining ten percent (10%), any charges in excess of the Allowable Amount, and all non-covered charges.

Preventive care services are paid at one hundred percent (100%) of the Allowable Amount. Members are responsible for any charges in excess of the Allowable Amount and all non-covered charges.

3. Emergency Care

Physician services for emergency care are paid at ninety percent (90%) of the Allowable Amount. Members are responsible for the remaining ten percent (10%) and all charges in excess of the Allowable Amount.

Hospital Services

1. Members Who Reside Within Area

a. When Accessing Preferred Hospitals:

Covered services rendered by a Preferred Hospital or Ambulatory Surgery Center are paid at ninety percent (90%) of the Negotiated Amount for covered services. Plan Members are responsible for the remaining ten percent (10%) of the lesser of Billed Charges or the Negotiated Amount for covered services and all charges for non-covered services.

NOTE: Members who reside within a Preferred Provider service area and receive services from a non-Preferred Provider will be reimbursed at the non-Preferred Provider level as stated in (b).

b. When Accessing Non-Preferred Hospitals:

Covered services rendered by a non-Preferred Hospital are paid at sixty percent (60%) of Reasonable Charges. Plan Members are responsible for the remaining forty percent (40%) and all charges for non-covered services.

c. Services Received from Non-Preferred Providers while receiving care at a Preferred Hospital:

Covered services rendered by non-Preferred Providers who are part of the Preferred Hospital or Ambulatory Surgery Center staff are paid at ninety percent (90%) of the Allowable Amount.* Plan Members are responsible for the remaining ten percent (10%) and all charges in excess of the Allowable Amount, plus all charges for non-covered services. For example, you may be admitted to a Preferred Hospital and certain physicians on that hospital's staff are non-Preferred Providers. These providers include anesthesiologists, radiologists and pathologists and other providers whose services are not included in and are not considered part of the Hospital or Ambulatory Surgery Center's charges.

*Although benefits are provided at the higher reimbursement level, it is still in your best financial interest to verify that all health care providers treating you are Preferred Providers. Whenever possible, you should request that all of your care be provided by Preferred Providers upon entering a Preferred Hospital or Ambulatory Surgery Center.

2. Members Who Reside Out-of-Area
(Refer to the list of qualifying ZIP Codes and Outside California information on page 10)

Covered services rendered to Plan Members who reside out-of-area are paid at ninety percent (90%) of Reasonable Charges. Members are responsible for the remaining ten percent (10%) and all charges for non-covered services.

3. Emergency Care

Covered services rendered by a Preferred Hospital incident to emergency care are paid at ninety percent (90%) of Billed Charges or ninety percent (90%) of the Negotiated Amount, whichever is less. Covered services rendered by a non-Preferred Hospital incident to emergency care are paid at ninety percent (90%) of Reasonable Charges. For both Preferred Hospitals and non-Preferred Hospitals, Plan Members are responsible for the remaining ten percent (10%) and all charges for non-covered services.

Emergency room facility charges for non-emergency care services are the Plan Member's responsibility. If your emergency room charges are rejected under this Plan because it is determined that they were for non-emergency care and you feel that your condition required emergency care services (as defined on page 79) you should contact Blue Cross and request a reconsideration. For more information, please see the Medical Claims Appeal Procedure section beginning on page 68.

NOTE: If a Member who is in a non-Preferred Hospital elects not to transfer or travel to a Preferred Hospital once his or her medical condition permits, reimbursement will be reduced to the sixty percent (60%) level and paid as stated in (1b). Hospital payments will be reduced if utilization review requirements are not met.

Skilled Nursing Facility

For Preferred Providers, inpatient services will be paid at:

- ninety percent (90%) of the Allowable Amount for the first ten (10) days each plan year. Members are responsible for the remaining ten percent (10%) of the Allowable Amount for covered services and ALL charges for non-covered services.

- eighty percent (80%) of the Allowable Amount for the next one hundred seventy (170) days in the same plan year. Members are responsible for the remaining twenty percent (20%) of the Allowable Amount for covered services and ALL charges for non-covered services.

For Non-Preferred Providers, inpatient services will be paid at:

- sixty percent (60%) of the Allowable Amount for each day during a covered stay. Members are responsible for the remaining forty percent (40%) of the Allowable Amount for covered services and ALL charges for non-covered services.

These benefits require a precertified treatment plan.

Home Health Care Agencies, Home Infusion Therapy Providers, and Durable Medical Equipment Providers

Preferred or out-of-area home health care agencies, home infusion therapy providers, and durable medical equipment providers will be reimbursed at ninety percent (90%) of Blue Cross of California's Allowable Amount or ninety percent (90%) of the local Blue Cross/Blue Shield plan's Allowable Amount. Members are responsible for the remaining ten percent (10%).

If you reside in-area, non-Preferred home health care agencies, home infusion therapy providers, and durable medical equipment providers will be reimbursed at sixty percent (60%) of Blue Cross of California's Allowable Amount or sixty percent (60%) of the local Blue Cross/Blue Shield plan's Allowable Amount. Members are responsible for the remaining balance.

Services provided by home health care agencies and home infusion therapy providers require a precertified treatment plan.

Services by Other Providers

Hospice care agencies will be reimbursed at ninety percent (90%) of Blue Cross of California's Allowable Amount or ninety percent (90%) of the local Blue Cross/Blue Shield plan's Allowable Amount. Members are responsible for the remaining ten percent (10%). Services by providers other than hospice care agencies (unless specifically provided otherwise) will be reimbursed at eighty percent (80%) of the lesser of Billed Charges or the amount that Blue Cross of California or the local Blue Cross/Blue Shield plan determines was being charged by the majority of providers of like-covered services at the time and in the area where services were provided. Members are responsible for the remaining twenty percent (20%) and for any charges in excess of these amounts.

NOTE:

1. Payment for covered services is limited to the lesser of the benefit maximum or the applicable Blue Cross of California or local Blue Cross/Blue Shield plan payment.

2. Payments will be reduced if utilization review requirements are not met.

FINANCIAL SANCTIONS

You may incur unnecessary medical expenses if the Review Center is not notified and involved in the precertification and management of your care. In order to promote compliance with utilization review notification requirements, financial sanctions (increased copayment responsibility) will be applied if you fail to notify the Review Center as required. In addition, if the Review Center determines that services are not medically necessary or are being provided at a level of care inconsistent with acceptable treatment patterns found in established managed care environments, financial sanctions will be applied and/or denial of all or some services may occur.

If you have questions about the application of a sanction based on the Review Center's decisions regarding compliance with late notification requirements, call the Review Center at 1-800-451-6780. If you do not agree with any portion of the Review Center's final determination, you or your physician may appeal this decision by following the Utilization Review Appeal Procedure described on pages 70 through 72.

For questions about how a sanction was applied to a specific claim, call Blue Cross at 1-877-737-7776.

Non-Compliance With Notification Requirements

A ten percent (10%) copayment (in addition to any other required copayment) will be applied to **all covered hospital charges** associated with the hospital stay in question if inpatient hospital services are received and (a) notification is late, or (b) precertification was not obtained even though services were approved after retrospective review.

A ten percent (10%) copayment (in addition to any other required copayment) will be applied to **outpatient facility charges and professional charges** if services listed under Utilization Review — Services Requiring Precertification on page 41 are received in an outpatient facility and (a) notification is late, or (b) services were approved after retrospective review.

This additional copayment amount will not accrue toward satisfying any other out-of-pocket deductible or maximum plan year copayment responsibility required under the payment design of the Plan.

Non-Compliance With Medical Necessity Recommendations for Temporomandibular Disorder Benefit or Maxillomandibular Musculoskeletal Disorders Benefit

A penalty of five hundred dollars ($500) will be assessed on inpatient charges or two hundred and fifty dollars ($250) on outpatient charges for (a) failure to obtain the required precertification from the Review Center, or (b) failure to comply with the Review Center's recommendation. This additional copayment amount will not accrue toward satisfying any other out-of-pocket deductible or maximum plan year copayment responsibility required under the payment design of the Plan.

Non-Certification of Medical Necessity

If the Review Center determines that services are not medically necessary or are being provided at a level of care inconsistent with acceptable treatment patterns found in established managed care environments, the Review Center will advise the treating physician and the patient, or a person designated by the patient, that coverage cannot be guaranteed. The actual amount of reimbursement will be determined retrospectively and will reflect appropriate sanctions, reductions, or denial of payment. For example, if you are hospitalized and the Review Center determines during the stay that treatment can be provided in a less acute setting, charges associated with the treatment would be reimbursed, but room and board charges for the number of days at the inappropriate level of care would not be reimbursed. Therefore, if the Review Center declines to certify services as medically necessary but you nevertheless choose to receive those services, you are responsible for all charges not reimbursed by the Plan.

MEDICAL AND HOSPITAL BENEFITS

Description of Benefits

Except for preventive care services, benefits are provided (subject to satisfaction of applicable deductibles) for medically necessary services and supplies that are delivered with optimum efficiency. Services and supplies that are not covered under the Plan are listed under Benefit Limitations, Exceptions and Exclusions beginning on page 51.

Services or a treatment plan precertified during a contract period must be commenced during that same contract period to qualify for continuing treatment in the event that the benefit becomes eliminated in a subsequent contract period. Otherwise, only benefits in effect during a contract period are available or covered.

Acupuncture

See Chiropractic Benefit.

Allergy Testing and Treatment

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Supplies, except for prescription drugs, related to allergy testing and treatment are covered. Charges incurred for office visits in conjunction with allergy treatment may not be payable. The plan year maximum for antigens is four hundred dollars ($400).

Alternative Birthing Center

80% in or out-of-area

Not subject to the plan year deductible and applies toward the maximum plan year copayment responsibility. An alternative birthing center as defined on page 77 may be used instead of hospitalization.

Ambulance

80% in or out-of-area

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility.

Emergency transportation by professional ambulance services (ground or air) required for emergency care (as defined in this EOC). Medically necessary professional ambulance services (ground or air) required to transfer the patient from one facility to another, including services provided as a result of a “911” emergency response system* request for assistance.

* If you have an emergency medical condition that requires ambulance transport services, please call the “911” emergency response system if you are in an area where the system is established and operating.

MEDICAL AND HOSPITAL BENEFITS

Ambulatory Surgery Centers

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Certain non-emergency procedures, services and surgeries require precertification by the Review Center. Precertification is required no later than three (3) business days prior to commencement of certain surgeries listed under Services Requiring Precertification on page 41. Precertification is required no later than thirty (30) business days prior to commencement of certain other surgeries also listed on page 41. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Chemical Dependency

The lifetime maximum payment for any combination of inpatient and outpatient chemical dependency services is twelve thousand dollars ($12,000).

Inpatient Care

90% PPO and out-of-area
60% non-PPO

Subject to the plan year and hospital admission deductibles and does not apply toward the maximum plan year copayment responsibility.

Precertification from the Review Center must be obtained three (3) business days prior to admission, or within twenty-four (24) hours or by the end of the first business day following an emergency admission, whichever is later. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Benefits are provided for hospital and physician services medically necessary for short-term (3 to 5 days) medical management of detoxification or withdrawal symptoms, **up to fifteen (15) days per plan year**. Inpatient charges in connection with chemical dependency rehabilitation services and programs are not a covered benefit.

Inpatient benefits may be utilized to cover outpatient day or evening chemical dependency treatment programs when precertified in advance by the Review Center, at the rate of two (2) day or evening treatments to equal one (1) full inpatient day treatment. The outpatient plan year maximum benefit will not exceed the equivalent of fifteen (15) inpatient days per plan year.

Outpatient Care

90% PPO and out-of-area
60% non-PPO

--Individual and group sessions
--Physician/psychiatrist visits for mental health drug management
--Physician/psychiatrist outpatient consultations
(any combination up to 30 visits per plan year)

Subject to the plan year deductible and does not apply toward the maximum plan year copayment responsibility.

For benefits to be payable, the provider must be a currently licensed physician or mental health provider.

Any treatment plan in excess of seven (7) visits per plan year must be precertified by the Review Center. Failure to obtain the required precertification may result in increased copayment responsibility and/or denial of benefits. For information on precertification, refer to page 41.

The intent of this benefit is to provide medically necessary treatment to stabilize an acute chemical dependency condition, up to thirty (30) visits per plan year.

Chiropractic and Acupuncture

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Any combination of services rendered by a licensed chiropractor or certified acupuncturist (for acupuncture or acupressure) up to twenty (20) visits per plan year.

Christian Science Treatment

80% in or out-of-area

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility.

Treatment or services of a Christian Science practitioner, Christian Science nurse, or Christian Science hospital. No payment, however, will be made for confinement in a Christian Science hospital for the purpose of rest or spiritual refreshment. This benefit includes treatment in absentia (defined on page 85).

Diabetes Self-Management Education Program

$20 Copay, PPO and out-of-area
60% non-PPO

The twenty dollar ($20) copayment to a Preferred Provider is not subject to the plan year deductible and does not apply toward the maximum plan year copayment responsibility. In addition, you will be required to continue to pay the $20 copayment for such visits even after you have reached the maximum plan year copayment responsibility amount.

Visits to a non-Preferred Provider are subject to the plan year deductible and the maximum plan year copayment responsibility is unlimited for visits to non-Preferred Providers.

Benefits are provided for patients enrolled in a diabetes instruction program for:

--The charges of a day care center for diabetes self-management education;

--The services of a physician or other health professional who is knowledgeable about the treatment of diabetes, such as a registered nurse, registered pharmacist and registered dietitian, provided that charges for such services do not duplicate those charged by a day care center.

A covered “diabetic instruction program” (1) is designed to educate patients and their family members about the disease process and the daily management of diabetic therapy; (2) includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and (3) is supervised by a physician.

Diagnostic X-Ray and Laboratory

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Outpatient services from all providers, including diagnostic X-rays, diagnostic examinations, clinical laboratory services, and Pap tests or mammograms for treatment of illness.

Outpatient magnetic resonance imaging (MRIs) of the upper and lower spine require precertification by the Review Center. Precertification must be obtained no later than three (3) business days prior to the commencement of services. Failure to obtain the required precertification from the Review Center within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Durable Medical Equipment

(Home Medical Equipment) and Prosthetic Appliances and Orthotics

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Rental or purchase, including repair and maintenance, of standard outpatient prosthetic appliances and standard durable medical equipment. Examples of prosthetic appliances include artificial limbs and eyes and their fitting, and orthopedic braces, including shoes only when permanently attached to such braces. Examples of durable medical equipment include crutches, standard wheelchairs and hospital beds. Lancets are covered for the purpose of administration of a covered drug.

The Plan covers rental charges up to the purchase price, or purchase, whichever is more cost-effective. Blue Cross will determine whether the Member is to purchase or continue to rent the equipment. If purchase is required, the Member will be notified to initiate the purchase of durable medical equipment by the Plan. After notification, the Plan will discontinue rental authorization.

Prosthetic, orthotic and durable medical equipment replacement and repairs resulting from loss, misuse, abuse and/or accidental damage are not a covered benefit of the Plan.

Refer to page 52 for Benefit Limitations, Exceptions and Exclusions related to this benefit.

Emergency Care Services

90% PPO, out-of-area or non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility.

A fifty dollar ($50) emergency room deductible applies for covered emergency room charges unless admitted to the hospital. If admitted to the hospital, the emergency room deductible is waived, and the two hundred and fifty dollar ($250) hospital admission deductible applies.

For inpatient hospital services, the Review Center must be notified within twenty-four (24) hours or by the end of the first business day following admission, whichever is later. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Services in a physician's office, outpatient facility or an emergency room of a hospital are covered when required for the alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen medical or psychiatric condition which, if not immediately diagnosed and treated, could lead to further disability or death, or which would so appear to a prudent layperson. This benefit includes emergency room physician visits.

Benefits are also provided for emergency maternity admissions if due to unexpected "premature" delivery. A premature delivery is one that occurs prior to the eighth (8th) month of pregnancy.

Only physician charges shall be payable for non-emergency services received in an emergency room of a hospital. The reimbursement level for physician or other charges will be based on the Preferred or non-Preferred status of the provider.

If a patient is in a non-Preferred Hospital, emergency benefits shall be payable until the patient's medical condition permits transfer or travel to a Preferred Hospital. If the patient does not wish to transfer to a Preferred Hospital, reimbursement shall be payable at the non-Preferred level for all subsequent charges.

Family Planning

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Services for voluntary sterilization, including tubal ligation and vasectomy, and medically necessary abortions are covered. Office visits for contraceptive management, including injectable drugs for birth control administered during the office visit and supplied by the physician, are covered. Intra-uterine devices (IUDs) are covered. Oral contraceptives are covered under the Outpatient Prescription Drug Program. Infertility services, including drugs for treating infertility, are not covered.

Refer to pages 53 and 55 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Hearing Aid Services

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Hearing aid services include an audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

The Hearing Aid

The hearing aid itself (monaural or binaural), including ear mold(s), the hearing aid instrument, initial battery cords, and other ancillary equipment, is subject to **a maximum payment of one thousand dollars ($1,000) per Member once every thirty-six (36) months.** The Plan provides payment of up to one thousand dollars ($1,000) regardless of the number of hearing aids purchased. This benefit also includes visits for fitting, counseling, adjustment, and repairs at no charge for a one-year period following the provision of a covered hearing aid. Refer to page 53 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Home Health Care

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Medically necessary skilled care for continued treatment of an injury or illness furnished by a Home Health Agency or Visiting Nurse Association is covered, up to **one hundred (100) visits** per plan year.

A treatment plan must be submitted in writing to the Review Center for precertification within three (3) business days prior to services being rendered. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

A physician must order the home health care and renew the order at least once every 30 days. Providers in California must be California-licensed Home Health Agencies or Visiting Nurse Associations. Other out-of-state providers must be recognized as home health care providers under Medicare.

A visit is defined as four (4) hours or less of covered services provided by one of the following providers:
a. A registered nurse;
b. A licensed therapist for physical, occupational, speech, or respiratory therapy;
c. A medical social service worker; or
d. A certified home health aide employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. A certified home health aide is covered only if you are also receiving the services of a registered nurse or licensed therapist employed by the same organization and the registered nurse is supervising the services. Custodial care is not covered.

Note:
- Speech therapy is subject to the limitations specified in the benefit description on page 33.
- Skilled nursing visits related to home infusion therapy will be counted against the 100 home health care visits per plan year.

Home Infusion Therapy

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Services and medications must be precertified by the Review Center as soon as possible, but no later than three (3) business days prior to commencement of services. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Home infusion therapy, including the cost of pharmaceuticals and medical supplies, is covered only if:
--The services are ordered by the Plan Member's physician;
--The services are determined to be medical necessity and appropriate; and
--The Member is homebound.

Skilled nursing visits, including skilled nursing visits in association with home infusion services, must be precertified by the Review Center. These visits are included under the Home Health Care benefit. For precertification requirements, see the Home Health Care benefit description beginning on page 28.

Hospice Care

90% in or out-of-area

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility.

The lifetime maximum payment is ten thousand dollars ($10,000).

Precertification from the Review Center must be obtained three (3) business days prior to obtaining hospice services.

To be eligible for hospice care benefits, charges must be incurred during a "benefit period" or period of bereavement which commences while the family unit is covered under PERSCare. Such charges must be made by, or under the direction of, a hospice program and incurred for a patient who is terminally ill as certified by his or her treating physician.

A benefit period begins on the date that the treating physician certifies that the patient is terminally ill and ends ninety (90) days after it began or on the date of the patient's death, whichever comes first. If the benefit period ends before the death of the patient, a new benefit period may begin if the treating physician certifies that the patient is still terminally ill. A period of bereavement begins on the date of the patient's death and ends ninety (90) days after it began even though coverage under PERSCare may have ended on the date of death.

Covered services are provided, under the direction of the treating physician, as follows:

--Full-time, part-time or intermittent skilled nursing service provided by a registered nurse or licensed vocational nurse in the home or in a hospice facility;

--Part-time or intermittent home health services that provide supportive care in the home or in a hospice facility;

--Homemaking services for the patient at the place of residence;

--Counseling for the patient and family. Family counseling includes no more than two (2) visits of bereavement counseling, up to ninety (90) days following the patient's death;

--Up to five (5) days of inpatient hospital care for the patient (respite care).

Hospital Benefits

90% PPO and out-of-area
60% non-PPO

All non-emergency hospitalizations, acute inpatient rehabilitation and specified outpatient procedures require precertification by the Review Center as soon as possible, but no later than three (3) business days prior to commencement of services (except for maternity care and admissions for mastectomy or lymph node dissection). Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits. For information on Emergency Care services, refer to page 27.

Inpatient Services

Subject to the hospital admission deductible for each admission. Not subject to the plan year deductible and the copayment applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Medically necessary accommodations in a semi-private room and all medically necessary ancillary services, supplies, unreplaced blood and take-home prescription drugs, up to a three (3) day supply. Covered benefits will not include charges in excess of the hospital's prevailing semi-private room rate unless your physician orders, and Blue Cross authorizes, a private room as medically necessary.

Outpatient Services

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Medically necessary diagnostic, therapeutic and/or surgical services performed at a hospital or outpatient facility, including, but not necessarily limited to, kidney dialysis, chemotherapy, and radiation therapy.

Maternity Care

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Medically necessary physician and hospital services relating to prenatal and postnatal care and complications of pregnancy. Examination, nursery care and circumcision of the newborn are provided if the newborn is enrolled as a family member. An alternative birthing center may be used instead of hospitalization.

Under the Newborns' and Mothers' Health Protection Act of 1996, the Plan may not limit length of stay to less than forty-eight (48) hours for normal vaginal delivery or ninety-six (96) hours for Cesarean section delivery. Any earlier discharge of a mother and her newborn child from the hospital must be made by the attending provider in consultation with the mother.

Refer to page 27 for emergency maternity admissions.

Mental Health Benefits

Inpatient Care

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and the hospital admission deductible. Does not apply toward the maximum plan year copayment responsibility.

Precertification from the Review Center must be obtained three (3) business days prior to admission, or within twenty-four (24) hours or by the end of the first business day following an emergency admission, whichever is later. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Benefits are provided for hospital and physician services medically necessary to stabilize an acute psychiatric condition **up to thirty (30) days per plan year**. Treatment for chronic psychiatric or psychological conditions, non-therapeutic treatment, custodial care and educational programs are not covered.

Inpatient benefits may be utilized to cover outpatient day or evening psychiatric hospital programs when precertified in advance by the Review Center at the rate of two (2) day or evening treatments to equal one (1) full inpatient day treatment. The outpatient plan year maximum benefit will not exceed the equivalent of thirty (30) inpatient days per plan year.

Refer to page 54 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Outpatient Care

90% PPO and out-of-area
60% non-PPO

--Individual and group sessions
--Physician/psychiatrist visits for mental health medication management
--Physician/psychiatrist outpatient consultations
(any combination up to 30 visits per plan year)

Subject to the plan year deductible and does not apply toward the maximum plan year copayment responsibility.

Any treatment plan in excess of seven (7) visits per plan year must be precertified by the Review Center. Failure to obtain the required precertification may result in increased copayment responsibility and/or denial of benefits. For information on precertification, refer to page 41.

For benefits to be payable, the provider must be a currently licensed physician or mental health provider.

The intent of this benefit is to provide medically necessary treatment to stabilize an acute psychiatric condition up to thirty (30) visits per plan year. Mental health treatment is limited to evaluation, crisis intervention, and treatment for conditions which are subject to significant improvement through short-term therapy. Treatment for chronic psychiatric or psychological conditions, non-therapeutic treatment, custodial care and educational programs are not covered. Visits for psychiatric care (defined on page 83), biofeedback, and psychological testing will be accrued against the maximum benefit of thirty (30) visits per plan year.

Refer to page 54 for Benefit Limitations, Exceptions and Exclusions of this benefit.

MEDICAL AND HOSPITAL BENEFITS

Natural Childbirth Classes

50% of class registration fee up to $50
(whichever is less)

Refresher classes — 50% of class registration
fee up to $25 (whichever is less)

Not subject to the plan year deductible and does not apply toward the maximum plan year copayment responsibility.

To prepare new and expectant parents for a natural birthing experience, the Plan will pay up to fifty dollars ($50) or fifty percent (50%) of total fees (whichever is less) for natural childbirth classes. Classes will be reimbursed only when given by licensed instructors certified by ASPO (American Society for Psychoprophylaxis in Obstetrics)/Lamaze Childbirth Educators. Refresher classes are also provided by the Plan up to twenty-five dollars ($25) or fifty percent (50%) of class fees (whichever is less).

Outpatient or Out-of-Hospital Therapies

Speech Therapy

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Subject to a **lifetime maximum payment of five thousand dollars ($5,000)**, the Plan will provide services by a qualified speech therapist holding a certificate of competence in clinical speech pathology with the American Speech and Hearing Association for the following:
--speech or swallowing disorder caused by documented illness or injury to the vocal organs or oral cavity; or
--speech or swallowing disorder due to:
a. stroke or injury to the brain;
b. congenital anomalies following corrective surgery; and or
c. cerebral palsy.

Except as specified above, speech therapy, speech correction or speech pathology services are not covered. No benefits are provided for the correction of:
--stammering, stuttering, lisping, tongue thrust, etc.;
--speech impediments caused by functional nervous disorders; or
--developmental speech delays.

Physical Therapy and Occupational Therapy

90% PPO and out-of-area (Physical Therapy)
60% non-PPO (Physical Therapy)
80% in or out-of-area (Occupational Therapy)

Subject to the plan year deductible and applies toward the maximum plan copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Upon referral by a physician, medically necessary services are covered when rendered by a licensed physical therapist or a licensed occupational therapist for the treatment of an acute condition.

Cardiac Rehabilitation

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Upon referral of a physician, medically necessary services are covered to a maximum of thirty (30) visits per plan year when provided by licensed personnel in a formal cardiac rehabilitation program.

Pulmonary Rehabilitation

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Upon referral of a physician, medically necessary services are covered to a maximum of thirty (30) visits per plan- year when provided by licensed personnel in a formal pulmonary rehabilitation program.

Physician Services

Physician Office Visits and
Physician Outpatient Hospital Visits

$20 Copay, PPO and out-of-area
60% non-PPO

The twenty dollar ($20) copayment applies only to the visit portion of the physician's bill. The $20 copayment to a Preferred Provider is not subject to the plan year deductible and does not apply toward the maximum plan year copayment responsibility. You will be required to continue to pay the $20 copayment for such visits even after you have reached the maximum plan year copayment responsibility amount. Other physician services rendered during an office visit or outpatient hospital visit are paid at ninety percent (90%) of the Allowable Amount (see Other Physician Services on page 35).

Visits to a non-Preferred Provider are subject to the plan year deductible; however, the maximum plan year copayment responsibility is unlimited for visits to non-Preferred Providers.

Other Physician Services

90% PPO and out-of-area
60% non-PPO

Physician services received during an office visit (e.g., lab work or stitching a wound) are subject to the plan year deductible and apply toward the maximum plan year copayment responsibility if services are received from Preferred Providers.

Services received from a non-Preferred Provider are subject to the plan year deductible; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

NOTE: Visits and consultations by an opthalmaologist for an active illness are covered under the Physician Services benefit described above. Physician visits in an emergency room are covered under the Emergency Care Services benefit. Physician services related to mental health or chemical dependency are covered under the Mental Health or Chemical Dependency benefit, respectively. Physician services related to surgery are covered under Hospital Benefits. Services related to chiropractic care are covered under the Chiropractic and Acupuncture benefit.

Prior Authorization is required for certain drugs that are dispensed and administered in a physician's office. For information on the Managed Prior Authorization Program, refer to page 44.

Preventive Care

100% PPO and out-of-area
60% non-PPO

Services received from Preferred Providers are not subject to the plan year deductible. Services received from non-Preferred Providers are subject to the plan year deductible, and the maximum plan year copayment responsibility is unlimited for services received from non-Preferred Providers.

Benefits include health care services designed for the prevention and early detection of illness in Members who have not experienced any symptoms. Preventive care generally includes routine physical examinations, tests and immunizations.

For purposes of this benefit, "preventive" means physician visits for preventive care services only and **excludes visits for treatment of illness or injury**.

Refer to page 86 for specific preventive care guidelines for children, adolescents, adults, and seniors.

Reconstructive Surgery

90% PPO and out-of-area
60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Precertification from the Review Center must be obtained as soon as possible, but no later than thirty (30) business days prior to commencement of services. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Hospital and physician services provided in connection with reconstructive surgery are a benefit only to the extent that surgery is coincident with and necessary to the repair or alleviation of bodily damage caused by illness, congenital birth defect, or accidental injury. Services must commence within ninety (90) days from the date on which the injury was sustained or within ninety (90) days of the date treatment was first medically appropriate.

Reconstructive surgery performed to restore symmetry following a mastectomy for documented medical pathology, such as cancer, is covered. Prosthetic devices and services provided in connection with a mastectomy are a benefit regardless of when the mastectomy was performed. Benefits are also payable for medically necessary services provided in connection with complications arising from reconstructive surgery which had been precertified and paid while a Member of PERSCare.

All reconstructive surgical services must be received while covered under this Plan.

Benefits are not payable for services provided in connection with complications arising from a non-authorized or cosmetic procedure.

Skilled Nursing Facility

First 10 days: 90% PPO and out-of-area
Next 170 days: 80% PPO and out-of-area
For all non-PPO services: 60%

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Admission and services in connection with confinement in a skilled nursing facility must be precertified by the Review Center as soon as possible, but no later than three (3) business days prior to admission. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Benefits are provided for medically necessary confinement in a skilled nursing facility, if necessary, instead of hospital confinement, up to one hundred-eighty (180) days combined for both Preferred Providers and non-Preferred Providers, during each plan year. Room and board charges in excess of the facility's established semi-private room rate are not covered. These benefits will only be provided if services are:

1. prescribed by the patient's physician;
2. for skilled and not custodial care; and
3. for the continued treatment of an injury or illness.

Temporomandibular Disorder (TMD) and Maxillomandibular Musculoskeletal Disorder Benefits

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

The lifetime maximum payment for any combination of diagnostic services and professional non-surgical or medical/conservative treatment is five thousand dollars ($5,000).

Temporomandibular Disorder (TMD)

90% PPO and out-of-area
60% non-PPO

Temporomandibular disorder (TMD) is a term that defines clinical problems of the masticatory musculature (muscles involved in chewing), the temporomandibular joint (TMJ), or both. TMJ refers to the joint that connects the lower jaw (mandible) to the skull. The diagnostic standard for TMD is based on an evaluation of the patient, history and clinical examination signs and symptoms supplemented, when appropriate, by X-rays or imaging.

Medically necessary treatment, including diagnostic services, non-surgical/medically conservative treatment, and surgical management for TMD, will be covered when the services and proposed treatment plan have been precertified by the Review Center.

Orthodontic appliances, splints, or braces used in preparation for orthodontia are not a Plan benefit (i.e., orthodontic services, including appliances, splints or braces either pre-operatively or post-operatively for jaw surgery, are not a Plan benefit). Refer to page 52 for Benefit Limitations, Exceptions and Exclusions listed under Dental Services, General.

Precertification from the Review Center must be obtained at least three (3) business days prior to diagnostic services and as soon as medical/surgical treatment is planned, but no later than thirty (30) business days prior to commencement of medical/surgical treatment. Failure to obtain the required precertification may result in increased copayment responsibility and/or denial of benefits. In addition, a penalty of five hundred dollars ($500) may be assessed on inpatient charges or two hundred and fifty dollars ($250) on outpatient charges for failure to comply with this requirement. **Medically necessary surgical management will be covered as determined by the Review Center only after failed non-surgical/medically conservative treatment has been completed and documented in the medical record.**

Maxillomandibular Musculoskeletal Disorders

90% PPO and out-of-area
60% non-PPO

Maxillomandibular musculoskeletal functional disorders are congenital or developmental skeletal deformities of the maxilla (upper jaw) and/or mandible (lower jaw).

Medically necessary treatment, including medical and surgical management for maxillomandibular musculoskeletal functional disorders, will be covered when there is a significant functional impairment.

Precertification from the Review Center of all maxillomandibular musculoskeletal surgical procedures must be obtained as soon as treatment is planned, but no later than thirty (30) business days prior to commencement of services. Failure to obtain the required precertification may result in increased copayment responsibility and/or denial of benefits. In addition, a penalty of five hundred dollars ($500) may be assessed on inpatient charges or two hundred and fifty dollars ($250) on outpatient charges for failure to comply with this requirement.

Orthodontic appliances, splints, or braces used in preparation for orthodontia are not a Plan benefit (i.e., orthodontic services, including appliances, splints or braces either pre-operatively or post-operatively for jaw surgery, are not a Plan benefit). Refer to page 52 for Benefit Limitations, Exceptions and Exclusions listed under Dental Services, General.

Transplant Benefits

Kidney, Cornea, and Skin Transplants

Hospital Services	90% PPO and out-of-area 60% non-PPO
Evaluations and Diagnostic Tests	90% PPO and out-of-area 60% non-PPO

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility if services are received from Preferred Providers; however, the maximum plan year copayment responsibility is unlimited if services are received from non-Preferred Providers.

Precertification for kidney, cornea, and skin transplants must be obtained from the Review Center as soon as possible, but no later than thirty (30) business days prior to commencement of services. Failure to obtain the required precertification within the specified time frame may result in increased copayment responsibility and/or denial of benefits.

Hospital and professional services provided in connection with human organ transplants are a benefit only to the extent that:

1. they are medically necessary and medically appropriate for the patient;
2. they are provided in connection with the transplant of a kidney, a cornea, or skin; and
3. the recipient of such transplant is a subscriber or dependent.

Covered expenses for the donor are limited to those incurred for medical services only. Reasonable Charges for services incident to obtaining the transplanted material from a living donor or a human organ transplant "bank" will be covered.

Special Transplant Benefit

Hospital Services:	90% at Blue Cross of California Centers of Expertise
Evaluations and Diagnostic Tests:	90% at Blue Cross of California Centers of Expertise

Subject to the plan year deductible and applies toward the maximum plan year copayment responsibility.

The Special Transplant Benefit is limited to the procedures listed below. These benefits will be covered only when prior **written** authorization has been obtained from Blue Cross' Corporate Medical Director and if the recipient of the transplant is a subscriber or dependent. Blue Cross' Corporate Medical Director shall review all requests for prior approval and shall approve or deny benefits based on (a) the medical necessity and medical appropriateness of the transplant for the patient, (b) the qualifications of the physicians who will perform the procedure, and (c) the referral of the subscriber or dependent to a facility that is an approved Blue Cross Center of Expertise (COE).

Pre-transplant evaluation and diagnostic tests, transplantation, and follow-ups will be allowed only at Blue Cross of California COEs. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities other than Blue Cross of California COEs will **not** be covered. Evaluation of potential candidates by Blue Cross of California COEs is covered subject to prior authorization. In general, more than one evaluation (including tests) within a short time period and/or at more than one Blue Cross of California COE will not be authorized unless the medical necessity of repeating the service is documented and the Review Center has reviewed the documentation and precertified the service.

For information on Blue Cross of California Centers of Expertise, call 1-800-451-6780.

Failure to obtain prior approval will result in denial of claims for this benefit.

The Special Transplant Benefit provision applies to:

--Human heart transplants
--Human lung transplants
--Human heart and lung transplants in combination
--Human liver transplants
--Human kidney and pancreas transplants in combination
--Human bone marrow transplants or autologous peripheral stem cell transplantation used to support high-dose chemotherapy (HDC)
--Pediatric human small bowel transplants
--Pediatric and adult human small bowel and liver transplants in combination

As with Preferred Providers, Blue Cross Centers of Expertise agree to accept the COE Negotiated Amount as payment for covered services. Plan Members are responsible for the remaining ten percent (10%) of the lesser of Billed Charges or the Negotiated Amount for covered services and all charges for noncovered services. Reasonable Charges for services incident to obtaining the transplanted material from a living donor or an organ transplant “bank” will be covered.

The Review Center’s Transplant Coordinator can assist in facilitating your access to a Blue Cross Center of Expertise. Please notify the Review Center at 1-800-451-6780 as soon as your provider recommends a transplant for your medical care.

COE providers are not available outside California; therefore, Plan Members who do not live in California will be referred by Blue Cross’ Transplant Coordinator to other qualified facilities.

UTILIZATION REVIEW

To determine whether services are medically necessary and efficiently delivered, Blue Cross' Review Center provides utilization review of all hospitalizations, including emergencies, and all the specified procedures/services and outpatient surgeries listed on page 41 under Services Requiring Precertification. Precertification by the Review Center is required before these benefits will be payable. Failure to obtain the required precertification under the terms and conditions specified in this document may result in increased liability or a complete denial of benefits.

The Review Center's services provide you with specific advantages:

- You will be provided with information that can help you qualify for the highest level of benefits under the Plan, thus minimizing your out-of-pocket costs.

- You will have telephone access to a clinical professional who can coordinate the review of your care. This Coordinator can assist in answering questions you may have about your proposed treatment.

For precertification of hospitalizations and of the procedures/services and outpatient surgeries specified under precertification, contact the Review Center at 1-800-451-6780. Although your provider may notify the Review Center of an upcoming non-emergency hospitalization or outpatient surgery/service requiring precertification, it is ultimately your responsibility, not your provider's, to call the Review Center. A Coordinator may need to speak with both you and your physician during the medical necessity review process.

If you elect to receive services from a different facility or provider after the Review Center has precertified a procedure, you must contact the Review Center again to obtain precertification.

UTILIZATION REVIEW

Precertification

Precertification is required no later than three (3) business days or thirty (30) business days (see below) prior to commencement of the procedure, service or surgery.

Remember, it is **your** responsibility, not your provider's, to call the Review Center. Failure to obtain precertification from the Review Center within the specified time frames will result in increased liability or complete denial if it is determined that the services were not medically necessary or not a covered benefit of the Plan.

Services Requiring Precertification

The following is a summary of the services requiring precertification.

3-Day Requirement	30-Day Requirement
Precertification is required no later than three (3) business days prior to commencement of the following procedures, services and surgeries: • Home infusion services • Inpatient hospitalization • Skilled nursing facility (see page 36) • Home health care (see page 28) • Hospice care (see page 30) • Mental health or chemical dependency outpatient visits (more than seven [7] per plan year; see pages 25 and 32) • Temporomandibular disorder (TMD) treatment and diagnostic services, including MRIs • Outpatient magnetic resonance imaging (MRIs) of the upper/lower spine • Septoplasty and sinus-related surgeries • Penile implant surgeries	Precertification is required no later than thirty (30) business days prior to commencement of the following procedures and surgeries: • Temporomandibular disorder (TMD) surgeries • Maxillomandibular musculoskeletal surgeries • Any plastic or reconstructive procedures/surgeries • Kidney, cornea and skin transplants

If you fail to obtain precertification from the Review Center for the services listed above, or if there are serious questions on the Plan's part as to the medical necessity or purpose for which a service was provided, the Review Center may review the services provided to you after they have been rendered. This is known as retrospective review. This review may result in a determination that reimbursement will be reduced or even denied under certain circumstances. Any subsequent adjustment in benefit levels as a result of retrospective review will be communicated to you in writing.

Even though services may be approved after retrospective review, financial sanctions may nevertheless be applied because of failure to obtain precertification from the Review Center.

UTILIZATION REVIEW

Emergency Admission

The Review Center must be notified of an emergency admission within twenty-four (24) hours or by the end of the first business day following admission, whichever is later, unless extraordinary circumstances prevent such notification within that time period. In determining "extraordinary circumstances," the Review Center may take into account whether your condition was severe enough to prevent you from notifying them, or whether no one was available to provide the notification for you. You may have to prove that such extraordinary circumstances were present at the time of the emergency.

The hospital, your physician, a family member, or a friend may call the Review Center if you are unable to call yourself. However, it is still your responsibility to make sure that the Review Center has been contacted. After the Review Center has been notified, a Coordinator will contact the hospital or your physician to obtain information on the recommended treatment plan.

Non-Emergency Admission

The Review Center must be contacted for precertification at least three (3) business days prior to a non-emergency inpatient hospital stay or outpatient surgery/service requiring Precertification. Precertification is not required for maternity admissions or admissions for mastectomy or lymph node dissection.

Staff in the Review Center may need to speak with both you (or the patient) and your physician prior to making their decision regarding medical necessity. During your hospital stay or ongoing treatment, the Review Center's staff will continue to manage and follow your care (known as concurrent review).

Although precertification is not required for inpatient hospital stays for maternity care, concurrent review will be performed if you remain in the hospital longer than 48 hours following a normal delivery or 96 hours following a Cesarean section delivery.

Staff in the Review Center will not contact you in the hospital regarding their recommendation without your permission. You may, however, advise the Review Center if you wish to be contacted in the hospital or if you wish to designate someone else to be contacted.

If you disagree with the Review Center's recommendation regarding continuing care, you or your physician may request a concurrent appeal by calling the Review Center. You do not need to leave the hospital or discontinue treatment; however, you may be liable for expenses beyond the date of the Review Center's precertification.

Refer to pages 70 through 72 for more information on utilization review appeal procedures.

Financial sanctions may be applied if the proposed hospital admission, outpatient surgery or other service is scheduled less than three (3) business days from the date you notify the Review Center. In this case, if you wish to meet the notification requirements, you may wish to discuss the pros and cons of postponing the service with your physician.

Case Management

The purpose of Case Management services is to assist PERSCare Members in obtaining high quality, cost-effective care. The Member, the Member's physician or the Plan may request that the Review Center perform Case Management services for those with multiple medical problems, for those who utilize extensive health care services, and for those who will benefit from assistance with coordination of health care services.

If Case Management services are requested for and accepted by a specific PERSCare Member, the Member will avoid higher out-of-pocket expenses by compliance and cooperation with the Review Center's Case Management services, even though the services under review may not be listed in the PERSCare Evidence of Coverage as needing the Review Center's review.

All services are subject to review for medical necessity by the Review Center for the patient in Case Management.

MANAGED Rx COVERAGE™ PROGRAM

As part of the Plan's drug program, Merck-Medco provides Managed Rx Coverage (MRxC) utilization management services. The purpose of the MRxC program is to establish appropriate threshold levels for specific drug therapy categories and to review patient cases exceeding these thresholds with providers. The MRxC program relies on clinically-based dosing and/or duration recommendations to set appropriate drug threshold limits. Within each therapy management category, clinical criteria or rules are applied to establish the thresholds at which a prescription will be rejected at the "Point-of-Sale."

The MRxC program provides a mechanism by which you or your physician may request a review of your prescription for authorization of coverage. The mechanism, or Point-of-Sale message, notifies the pharmacist with a message **"Plan Limits Exceeded"** or **"Prior Authorization Required"** along with an 800 number. The pharmacist can use this 800 number to initiate the review process. This process is usually completed within twenty-four (24) hours. You will receive written notification of approval or denial.

If, upon review, utilization is found to be within the scope of the benefit, coverage is provided. When approved, the prescription can be filled immediately by any retail Participating Pharmacy (PAID) or through the mail service (Merck-Medco Rx Services). If, upon review, coverage cannot be provided, MRxC provides a mechanism for an appeal of the coverage decision by your physician. Just have your physician contact Merck-Medco for an appeals review. If the prescription quantity request is denied, charges for administering the drug in excess of the approved amount will not be covered.

Drug therapies subject to review through the Managed Rx Coverage Program include the following categories (a few examples are shown in parentheses):

Antidepressant Therapy (Wellbutrin SR only)
Antiemetic Therapy Management (Kytril, Zofran)
Anti-Influenza Therapy (Relenza, Tamiflu)
Anti-Secretory Therapy (Prilosec, Zantac)
COX-2 Inhibitor Therapy (Celebrex, Vioxx)
Erectile Dysfunction Therapy* (Muse, Viagra)
Migraine Therapy Management (Imitrex, Zomig)
NSAID Therapy* (Toradol only)
Onychomychosis (Lamisil, Sporanox)
Paget's Disease Management* (Actonel)
Pain Therapy Management (Stadol NS)
Vaginitis Therapy* (Diflucan 150mg.)

*No Coverage Review on these products.

Drugs in the above categories will be identified to the dispensing pharmacist by the message **"Plan Limits Exceeded"** or **"Prior Authorization Required"** depending on the drug or drug category. Other drug or drug categories may be added to the list at the discretion of the PERSCare Plan.

MANAGED PRIOR AUTHORIZATION PROGRAM FOR PRESCRIPTION DRUGS

As part of the Plan's drug program, Merck-Medco provides Managed Prior Authorization services. The purpose of Prior Authorization is to ensure that certain drugs, including but not limited to those listed below, are used in accordance with specific criteria determining medical appropriateness and cost-effectiveness. These drugs require Prior Authorization before payment for the drug and any services received in a physician's office or at an infusion center can be approved. If Prior Authorization is denied, charges for administering the drug will not be covered.

Drugs Purchased Through The Retail Pharmacy Program (PAID Prescriptions)

When a prescription requires Prior Authorization, the pharmacy is notified before the drug is dispensed. Your physician is then contacted by a Merck-Medco pharmacist to verify that the prescribed medication meets the Plan's approved guidelines. This process is usually completed within twenty-four (24) hours. You will receive written notification of approval or denial. When approved, the prescription can be filled immediately by any retail Participating Pharmacy (PAID) or through mail service (Merck-Medco Rx Services). If necessary, the prescription can be refilled until the Prior Authorization termination date disclosed in the letter of approval. You must then have the authorization renewed if the prescription is to continue. If Prior Authorization is denied, you will be notified in writing.

Drugs Dispensed and Administered in a Physician's Office or at an Infusion Center

When a prescription requiring Prior Authorization is dispensed and administered in a physician's office or at an infusion center, the physician is required to submit a Prior Authorization Request to Merck-Medco.

Drugs Requiring Prior Authorization

Prior Authorization is required for brand-name drugs and their generic equivalents in the following drug categories (a few examples are shown in parentheses):

Acne Therapy (Accutane, Retin-A)

Amphetamines (Adderall, Desoxyn)

CNS Stimulants (Ritalin, Cylert)

Erythroid Stimulants (Epogen/Procrit)

Fertility Drugs (Clomid, Lupron) Note: Drugs for the treatment of infertility are not covered

Growth Hormones (Nutropin, Protropin)

Immune globulins (Gammar, Gammagard)

Interferons (Betaseron, Infergen)

Miscellaneous Biotechnology Agents (Copaxone)

Myeloid Stimulants (Leukine/Neupogen)

Rheumatoid Arthritis Agents (Enbrel)

Drugs in the above categories will be identified to the dispensing pharmacist by the message "**Prior Authorization Required.**" Other drugs may be added to the list at the discretion of the PERSCare Plan.

For more information regarding Managed Prior Authorization, call 1-800-316-9178 or write to:

Merck-Medco Managed Care, L.L.C.
100 Parsons Pond Rd.
Franklin Lakes, NJ 07054

OUTPATIENT PRESCRIPTION DRUG PROGRAM

The Outpatient Prescription Drug Program is administered by Merck-Medco Managed Care, L.L.C. through its subsidiaries PAID Prescriptions, L.L.C, and Merck-Medco Rx Services. This program will pay for prescription drugs which are: (a) prescribed in connection with a covered illness or accidental injury; (b) dispensed by a registered pharmacist, subject to the exclusions listed on pages 49 and 50; (c) approved through the Managed Rx Coverage Program described on page 43; and (d) approved through the Managed Prior Authorization Program as described on page 44.

The Plan's drug program is designed to save you money by encouraging you to ask your physician to prescribe generic drugs whenever possible and to prescribe drugs under Merck-Medco's Preferred Prescriptions Incentive Formulary. In an incentive-based formulary arrangement, the same list of formulary medications remains in place; however, a higher copayment is charged for non-formulary medications. Patients can still receive any covered drug and your physician still maintains the choice of drug prescribed. This incentive formulary, available through the Retail Pharmacy Program and the Mail Service Program, provides maximum savings to the Plan without compromising safety and efficacy standards. A listing of the drug formulary can be obtained by calling Merck-Medco Member Services at 1-800-316-9178, or by visiting the Web site at www.merckmedco.com.

Coordination of Benefits provisions do not apply to the Outpatient Prescription Drug Program.

Outpatient Prescription Drug Benefits

Outpatient prescription drugs prescribed in connection with a covered illness or accidental injury and dispensed by a registered pharmacist may be obtained either through the Retail Pharmacy Program (PAID Prescriptions, L.L.C.) or the Mail Service Program (Merck-Medco Rx Services).

Your copayment will vary based on which program you use, whether you use generic or brand-name drugs, and whether your brand-name drug is on the Preferred Prescriptions Formulary. To find out if your medication is on the Preferred Prescriptions Formulary, call Merck-Medco Member Services at 1-800-316-9178, or visit the Web site at www.merckmedco.com.

Copayment Structure

The following table shows the copayment structure for the retail pharmacy and mail service programs:

Retail Pharmacy	
Generic	**$5.00** per prescription
Formulary Brand	**$15.00** per prescription
Non-Formulary Brand	**$30.00** per prescription 34-day supply
Mail Service	
Generic	**$10.00** per prescription
Formulary Brand	**$25.00** per prescription
Non-Formulary Brand	**$45.00** per prescription 90-day supply

The copayment applies to each prescription order and to each refill. The copayment is not reimbursable and cannot be used to satisfy any deductible requirement.

All prescriptions filled by mail service will be filled with an FDA-approved bioequivalent generic substitute if one exists, unless the physician specifies otherwise.

A one thousand dollar ($1,000) maximum plan year copayment (per person) applies to mail order prescriptions.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Retail Pharmacy Program

(PAID Prescriptions, L.L.C.)

Medication for a short duration, up to a 34-day supply, may be obtained from a Participating Pharmacy by using your PERSCare ID card.

While this program was designed primarily for use in California, there are many Participating Pharmacies outside California that will also accept your PERSCare ID card. At Participating Pharmacies, simply show your ID card and pay either a five dollar ($5.00) copayment for generic drugs, a fifteen dollar ($15.00) copayment for formulary brand-name drugs, or a thirty dollar ($30.00) copayment if your brand-name drug is not on the Preferred Prescriptions Formulary. If the pharmacy does not accept your ID card, please follow the procedure for using a non-Participating Pharmacy described below.

How To Use The Retail Pharmacy Program

(Both In-State and Out-of-State Pharmacies)

Participating Pharmacy

1. Take your prescription to any Participating Pharmacy. To locate a Participating Pharmacy near you, call Merck-Medco Member Services at 1-800-316-9178, or visit the Web site at www.merckmedco.com.

2. Present your PERSCare ID card to the pharmacist.

3. The pharmacist will fill the prescription for up to a thirty-four (34) day supply of medication.

4. You will be required to sign a receipt for the prescription and pay the pharmacist your appropriate copayment for each prescription order or refill.

NOTE: Submit a Direct Reimbursement Claim form available from PAID Prescriptions if you pay a Participating Pharmacy the full cost of your medication at the time of purchase without presenting your ID card. Your reimbursement will be the same as if you had used a non-Participating Pharmacy (see the following example).

Non-Participating Pharmacy

If you purchase drugs at a non-Participating Pharmacy, either inside or outside California, you will be required to pay the full cost of the medication at the time of purchase. To receive reimbursement, complete a Direct Reimbursement Claim form and mail it to the address indicated on the form. **Claims must be submitted within twelve (12) months from the date of purchase**.

Payment will be made directly to you. It will be based on the amount covered for a Participating Pharmacy minus the appropriate copayment (five dollars [$5.00] for each generic drug, fifteen dollars [$15.00] for each formulary brand-name drug, and thirty dollars [$30.00] for each non-formulary brand-name drug).

Example of Direct Reimbursement Claim for a Formulary Brand-Name Drug

1. Pharmacy charge to you (Retail Charge).....$38.00
2. Participating Pharmacy covered charge (PAID's Allowable Amount).....$20.00
3. Amount in excess of PAID's Allowable Amount.....$18.00
4. Your copayment (Formulary Brand-Name) $15.00
5. Your out-of-pocket cost (Line 3 plus line 4) $33.00
6. Your reimbursement (Line 1 minus line 5).....$ 5.00

As you can see, using non-Participating Pharmacies, or not using your ID card at a Participating Pharmacy, may result in substantial cost to you. Under certain circumstances, PAID's Allowable Amount may be below your copayment amount and no reimbursement would be allowed.

NOTE: Covered drugs purchased from your physician will be reimbursed under the non-Participating Pharmacy benefit through PAID Prescriptions.

Direct Reimbursement Claim Forms

Direct Reimbursement Claim forms and information on Participating Pharmacies outside California are available from:

PAID Prescriptions, L.L.C.
399 Jefferson Road
Parsippany, NJ 07054
Attention: Member Services
1-800-316-9178
www.merckmedco.com

Mail Service Program

(Merck-Medco Rx Services)

Maintenance medication for ongoing or chronic conditions may be obtained by mail, for up to a ninety (90) day supply, through Merck-Medco Rx Services.

Mail service offers additional savings and convenience if you need prescription medication on an ongoing basis. For example:

- **Additional Savings**: You can receive up to a ninety (90) day supply of medication for only ten dollars ($10.00) for each generic drug, twenty-five dollars ($25.00) for each formulary brand-name drug, or forty-five dollars ($45.00) for each non-formulary brand-name drug. In addition to saving two copayments, you save additional trips to the pharmacy.
- **Convenience**: Your medication is delivered to your home.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

- **Security:** You can receive larger quantities of medication at one time.
- **A toll-free customer service number**: Your questions can be answered by calling a Merck-Medco Rx Services representative or pharmacist at 1-800-316-9178.
- **Out-of-pocket maximum**: Your maximum plan year copayment (per person) is one thousand dollars ($1,000).

How To Use The Mail Service Program

If you must take medication on an ongoing basis, the Mail Service Program is ideal for you. To use this program, just follow these steps:

1. Ask your physician to prescribe needed medications for up to a ninety (90) day supply, plus refills if appropriate.
2. Send the following to Merck-Medco Rx Services in the postage-paid, pre-addressed envelope:
   a. the original prescription order(s) your physician gives you.
   b. the completed Health Assessment Questionnaire with your first order only. The questionnaire is included in your annual enrollment package, or it can be obtained by calling:
   Merck-Medco Member Services
   1-800-316-9178
   c. a check or money order for an amount that covers your copayment for *each* prescription: $10 generic, $25 formulary brand-name, or $45 non-formulary brand-name. Checks or money orders should be made payable to *Merck-Medco Rx Services.* You can also have your copayment(s) charged to your credit card.
3. To order your mail service refill:
   a. Send in your refill request at least three (3) weeks before your supply runs out. Requests for refills sent in earlier will be held at Merck-Medco Rx Services until the allowed refill date, and then dispensed and shipped to you.
   b. For your convenience, you can order your refills, request renewals or order new prescriptions on-line at www.merckmedco.com.

Merck-Medco Rx Services will process your order and send your medication(s) to you by way of first-class mail (or UPS for controlled substances) along with instructions for reordering future prescriptions and/or refills, if any. Please allow up to fourteen (14) days for delivery of your medication(s).

To find out if your medication is on the Preferred Prescriptions Formulary, call Merck-Medco Member Services at 1-800-316-9178, or visit the Web site at www.merckmedco.com.

All prescriptions will be filled with an FDA-approved bioequivalent generic substitute if one exists, unless your physician specifies otherwise.

For information or if you have questions regarding the Mail Service Program, contact:

PERSCare Health Plan
Merck-Medco Rx Services
P.O. Box 3939
Spokane, WA 99220-9870
1-800-316-9178

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Program:

1. Drugs or medicines obtainable without a physician's prescription, often called over-the-counter (OTC) drugs, except insulin and glucose test strips.

2. Contraceptives in the form of condoms, jellies, ointments, foams, patches, time-released subdermal drugs (e.g., Norplant implants), or devices.

3. Dietary and herbal supplements, minerals, health aids, and any vitamins whether available over the counter or by prescription, except Rocaltrol (Calcitriol), DHT and Hytakerol (Dihydrotachysterol) and Calderol (Calcifediol).

4. Anorexiants and appetite suppressants.

5. Anti-dandruff preparations.

6. Laxatives, except as prescribed for diagnostic testing.

7. Supplemental fluorides.

8. Charges for the purchase of blood or blood plasma.

9. Hypodermic needles and syringes, except as required for the administration of a covered drug.

10. Non-medical therapeutic devices or appliances, including support garments and other such items or appliances, regardless of their intended use.

11. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.

12. Drugs designed solely for or used to deter smoking.

13. Drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs.

14. Any drugs prescribed solely for the treatment of an illness, injury or condition which is excluded under the Plan.

15. Any drugs or medications which are not legally available for sale within the continental United States.

16. Any charges for injectable immunization agents, allergy sera, or biological sera, including the administration thereof. These charges are covered under the Medical and Hospital Benefits provision.

17. Any charge for the administration of prescription drugs or injectable insulin. These charges (i.e. lancets) are covered under the Medical and Hospital Benefits provision.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

18. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a hospital or extended care facility. These charges are covered under the Medical and Hospital Benefits provision.

19. Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers. These charges are covered under the Medical and Hospital Benefits provision.

20. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or medication furnished by any other drug or medical service for which no charge is made to the Plan Member.

21. Any quantity of dispensed drugs or medicines which exceeds a thirty-four (34) day supply, unless prescribed for chronic conditions and obtained through the Mail Service Prescription Drug Program. Mail service prescriptions are limited to a ninety (90) day supply of covered drugs or medicines as prescribed by a physician.

22. Refills of any prescription in excess of the number of refills specified by a physician.

23. Any drugs or medicines dispensed more than one (1) year following the date of the physician's prescription order.

24. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a non-Participating Pharmacy, or the mail service pharmacy.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

No one has the right to receive any benefits of this Plan following termination of coverage, except as specifically provided under the Benefits After Termination or Continuation of Group Coverage provisions in this booklet.

Administrative remedies for requests for exemption from benefit limitations, exceptions or exclusions are available only under the following circumstances: If a service or procedure has been denied for the reason that it is not a covered benefit of the Plan, or that it is a limitation, exception or exclusion of the Plan, the Member must demonstrate that the limitation, exception or exclusion is prohibited by law and establish that the service or procedure is medically necessary according to Blue Cross' Medical Policy.

Benefits are subject to review for medical necessity before, during and/or after services have been rendered. Refer to page 14 for the Medical Necessity provision and to pages 40 through 42 for utilization review standards and procedures.

The title of each exclusion is not intended to be fully descriptive of the exclusion; rather, it is provided solely to assist the Plan Member to easily locate particular items of interest or concern. Remember, a particular condition may be affected by more than one exclusion.

Under no circumstances will the Plan be liable for payment of costs incurred by a Plan Member or dependent for treatment deemed by CalPERS or its Plan administrators to be experimental or investigational or otherwise not eligible for coverage.

General Exclusions

Benefits of this Plan are not provided for or in connection with* the following:

1. **Acute Inpatient Rehabilitation**. Acute inpatient rehabilitation is excluded unless precertified as medically necessary by Blue Cross.

2. **Aids and Environmental Enhancements**

   a. The rental or purchase of aids, including, but not limited to, ramps, elevators, stairlifts, swimming pools, spas, hot tubs, air filtering systems or car hand controls, whether or not their use or installation is for purposes of providing therapy or easy access.

   b. Any modification made to dwellings, property or motor vehicles, whether or not their use or installation is for purposes of providing therapy or easy access.

3. **Benefit Substitution/Flex Benefit/In Lieu Of.** Any program, treatment, service, or benefit cannot be substituted for another benefit or non-existing benefit. For example, receiving home health care benefits in lieu of an admission to a skilled nursing facility**.**

4. **Blood and Blood Products**. Charges incurred for the purchase of blood or blood products when the blood has been replaced.

5. **Close-Relative Services**. Charges for services performed by a close relative or by a person who ordinarily resides in the Plan Member's home.

* **The phrase "in connection with" means any medical condition associated with an excluded medical condition** (i.e., an integral part of the excluded medical condition or derived from it).

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

6. **Convenience Items and Non-Standard Services and Supplies**. Services and supplies determined by the Plan as not medically necessary or generally furnished for the diagnosis or treatment of the particular illness, disease or injury; or services and supplies which are furnished primarily for the convenience of the Plan Member, irrespective of whether or not prescribed by a physician.

7. **Cosmetic Procedures**. Services and supplies determined by the Plan to be furnished for cosmetic purposes or any complications resulting from such procedures.

8. **Custodial Care**

   a. Custodial care provided either in the home or in a facility, unless provided under the Hospice Care Benefit.

   b. Services provided by a rest home, a home for the aged, a custodial nursing home, or any similar facility.

9. **Dental Implants**. Dental implants and any related services.

10. **Dental Services, General**. Dental services, as determined by the Plan, include, but are not limited to, services customarily provided by dentists in connection with the care, treatment, filling, removal, or replacement of teeth; treatment of gums (other than for tumors); treatment of dental abscess or granuloma; dentures; and preparation of the mouth for dentures (e.g., vestibuloplasty). Services related to bone loss from denture wear or structures directly supporting the teeth are excluded.

    Also excluded are dental services in connection with prosthodontics (dental prosthetics, denture prosthetics designed for the replacement of teeth or the correction, alteration or repositioning of the occlusion), orthodontia (dental services to correct irregularities or malocclusion Classes I through IV of the teeth) for any reason, orthodontic appliances (except for acrylic splint as covered under the Temporomandibular Disorder [TMD] benefit), braces, bridges (fixed or removable), dental plates, pedodontics (treatment of conditions of the teeth and mouth in children) or periodontics, and dental implants (endosteal, subperiosteal or transosteal).

    Acute care hospitalization and anesthesia services may be covered in connection with dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status. Services of a dentist or oral surgeon are excluded.

11. **Durable Medical Equipment**. The following are examples of items which are not covered under this benefit: speech devices; dental braces and other orthodontic appliances; orthopedic shoes (except when joined to braces) or shoe inserts; air conditioners, humidifiers, dehumidifiers or air purifiers, exercise equipment, or any other equipment not primarily medical in nature; and supplies for comfort, hygiene or beautification, including wigs. Prosthetic, orthotic and durable medical equipment replacement and repair resulting from loss, misuse, abuse and/or accidental damage are not covered.

12. **Excess Charges**. Any expense incurred for covered services in excess of Plan benefits or maximums.

13. **Experimental or Investigational Practices or Procedures**. Experimental or investigational practices or procedures, and services in connection with such practices or procedures, as defined on page 79.

14. **Eye Examinations**. Eye refraction or other examinations in preparation for eyeglasses or contact lenses; vision therapy; orthoptics; eyeglass or contact lens prescriptions, unless following cataract surgery, or, if necessary, for the repair or alleviation of accidental injury sustained while covered under this Plan.

15. **Eye Surgery, Corrective**. Any procedure done to correct a refractive error, including surgeries such as radial keratotomy, optical keratoplasty, or myopic keratomileusis.

16. **Feet, Procedures Affecting**. Callus or corn paring or excision, or toenail trimming. Any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain.

17. **Government-Provided Services**. Any services provided by a local, state, or federal government agency unless reimbursement by this Plan for such services is required by state or federal law.

18. **Hearing Conditions**

    a. Purchase of hearing aid batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.

    b. Charges for a hearing aid which exceeds specifications prescribed for correction of hearing loss.

    c. Replacement parts for hearing aids or repair of hearing aids after the covered one-year warranty period.

    d. Replacement of a hearing aid more than once in any period of thirty-six (36) months.

    e. Surgically implanted hearing devices.

19. **Hospital Admission**. Inpatient charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

20. **Infertility, Diagnosis/Treatment**. Laboratory, X-ray procedures, medication or surgery solely for the purpose of diagnosing and/or treating infertility of a Plan Member, including, but not limited to, reversal of surgical sterilization, artificial insemination, in vitro fertilization, or complications of such procedures.

21. **Marriage and Family Counseling**. Counseling for the sole purpose of resolving conflicts between a subscriber and his or her spouse or children.

22. **Maternity**. Maternity benefits are not provided for services subsequent to termination of coverage under this Plan unless the patient qualifies for an extension of benefits as described under Benefits After Termination on page 66, or qualifies under the provisions described under Continuation of Group Coverage on page 63 or Continuation of Group Coverage After COBRA on page 64. See Emergency Care Services on page 27 for
benefit coverage of emergency maternity admissions.

23. **Medical Trainee Services**. Services performed in any inpatient or outpatient setting by house officers, residents, interns and others in training.

24. **Natural Childbirth Classes**. Natural childbirth classes will be reimbursed only when given by certified ASPO/Lamaze childbirth educators. Classes devoted solely to individual perinatal specialties, other than Lamaze, are not covered.

25. **Nicotine Addiction**. Any programs, services, or devices related to the treatment of nicotine addiction.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

26. Non-Listed Benefits. Services not specifically listed as benefits or not reasonably medically linked to or connected with listed benefits, whether or not prescribed by a physician.

27. Nutrition. Vitamins, minerals, and nutritional supplements whether or not prescribed by a physician; nutritional counseling or food supplements taken orally, except as specifically provided under the Diabetes Self-Management Education Program provision or the Outpatient Prescription Drug Program section.

28. Organ Transplants. Charges incident to organ transplants, except as specifically provided under Kidney, Cornea, and Skin Transplants or Special Transplant Benefits.

29. Personal Development Programs. For or incident to vocational, educational, recreational, art, dance, music, reading therapy, or exercise programs (formal or informal).

30. Private-Duty Nursing

a. Private-duty skilled nursing, unless provided under the Home Health Care or Hospice Care benefits.

b. Private-duty unskilled nursing.

31. Psychiatric or Psychological Care

a. Treatment of the following conditions is excluded under this Plan:

1. personality disorders;
2. sexual deviations and disorders;
3. abuse of drugs;
4. conduct disorders;
5. mental retardation and developmental delays;
6. conditions of abnormal behavior which are not directly attributed to a mental disorder which is the focus of attention or treatment;
7. attention deficit disorders.

b. Telephone consultations.
c. Psychological testing or testing for intelligence or learning disabilities unless medically necessary to assess brain function suspected to be impaired due to trauma or organic dysfunction.
d. Inpatient treatment for eating disorders.
e. Services on court order or as a condition of parole or probation unless the services are determined to be medically necessary and appropriate for the condition being treated and otherwise covered by the Plan.
f. Marriage and family counseling for the sole purpose of resolving conflicts between a subscriber and his or her spouse or children.
g. Non-therapeutic treatment, custodial care and educational programs.

NOTE: Any dispute regarding a psychiatric condition will be resolved with reference to the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), Fourth Edition. Washington, DC, American Psychiatric Association, 1994. Use of DSM-IV to resolve disputes is subject to change as new editions are published.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

32. Rehabilitation or Rehabilitative Care

a. Inpatient charges in connection with a hospital stay primarily for environmental change, or treatment of chronic pain unless provided under the Hospice Benefit.

b. Inpatient charges in connection with rehabilitation services and programs for mental health and chemical dependency treatment, and eating disorders.

c. Outpatient charges in connection with conditioning exercise programs (formal or informal).

d. Any testing, training or rehabilitation for educational, developmental or vocational purposes.

33. Residential Treatment Facility. Charges associated with an inpatient stay at a residential treatment facility, transitional living center, or board and care facility.

34. Sexual Transformations. Charges for or incident to intersex surgery (transsexual operations) or any resulting medical complications.

35. Speech Therapy. Charges for speech therapy due to functional nervous disorders are not covered. Benefits are not provided for speech therapy, speech correction or speech pathology except as specifically provided in the Speech Therapy benefit description on page 33.

36. Telephone, Facsimile Machine, and E-mail Consultations. Telephone, facsimile machine, and e-mail consultations for any purpose, whether between the physician or other provider and the subscriber or subscriber's family, or involving only physicians or other providers.

37. Totally Disabling Conditions. Services or supplies for the treatment of a total disability, if benefits are provided under the extension of benefits provisions of (a) any group or blanket disability insurance policy, or (b) any health care service plan contract, or (c) any hospital service plan contract, or (d) any self-insured welfare benefit plan.

38. Treatment Plan. Benefits are not payable for a written or oral treatment plan submitted or given for the purpose of claim or medical necessity review. Services or a plan of treatment preauthorized by the Plan during a contract period must be commenced during the same contract period. To qualify for continuing treatment in a subsequent contract period, the services or plan of treatment must be reauthorized. Otherwise, only the benefits in effect during a contract period are available or covered.

39. Vasectomy or Tubal Ligation. Services for or incident to the reversal of a vasectomy or tubal ligation, or for repeat vasectomy or tubal ligation.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

40. **Voluntary Payment of Non-Obligated Charges**. Services for which the Plan Member is not legally obligated to pay, or services for which no charge is made to the Plan Member in the absence of health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

    a. It must be internationally known as being devoted mainly to medical research, and

    b. At least ten percent (10%) of its yearly budget must be spent on research not directly related to patient care, and

    c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and

    d. It must accept patients who are unable to pay, and

    e. Two-thirds of its patients must have conditions directly related to the hospital's research.

41. **War**. Conditions caused by war, whether declared or undeclared.

42. **Weight Control**. Any program, treatment, service, supply, or surgery for dietary control, weight control, or complications arising from weight control, whether or not prescribed or recommended by a physician, including but not limited to:

    a. exercise programs (formal or informal) and equipment;

    b. surgeries, such as gastric bubble, gastric stapling, or liposuction.

43. **Workers' Compensation, Services Covered By**. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of the injury or disease.

Limitation Due to Major Disaster or Epidemic

In the event of any major disaster or epidemic, Preferred Providers shall render or attempt to arrange for the provision of covered services insofar as practical, according to their best judgment, within the limitations of such facilities and personnel as are then available; but neither the Plan, Blue Cross, nor Preferred Providers have any liability or obligation for delay or failure to provide any such services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.

BLUE CROSS OF CALIFORNIA

Blue Cross of California works with an extensive network of "Preferred Providers" throughout California. These providers participate in our preferred provider organization program (PPO), called the Prudent Buyer Plan. They have agreed to accept payment amounts set by Blue Cross for their services. These "Allowable Amounts" are usually lower than what other physicians and hospitals charge for their services, so your portion of the charges, or your copayment, will also be lower.

The Plan's Preferred Provider Network also includes BlueCard providers for members who live or are traveling outside California. The Blue Cross and Blue Shield Association, of which Blue Cross of California is a member, has a program (called the "BlueCard Program") which allows our Members to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Plans. BlueCard network providers are located throughout the United States. Preferred Providers (BlueCard providers) have agreed to accept Allowable Amounts set by their local Blue Cross/Blue Shield plan as payment for covered services. See page 11 for a further description of how the BlueCard Program works.

When you need health care, simply present your PERSCare ID card to your physician, hospital, or other licensed health care provider. Choosing Preferred Providers for your health care allows you to take advantage of the highest level of reimbursement. Prior to receiving services you should verify that the provider is a Preferred Provider, in case there have been any changes since your Preferred Provider directory was published.

Preferred Providers have agreed to accept Blue Cross of California's payment, plus applicable deductibles and copayments, as payment in full for covered services. When you receive covered services from a Preferred Provider, the provider will be paid directly. This means you have no further financial responsibility, except for any deductibles or copayments that may apply, and therefore no claim forms to file.

If you go to a non-Preferred Provider, payment for services may be substantially less than the amount billed. In addition to your deductible and copayment, you are responsible for any difference between the Allowable Amount and the amount billed by the non-Preferred Provider.

Claims Submission

You will be reimbursed directly by Blue Cross of California for covered services rendered by a non-Preferred Provider. Also, non-Preferred Providers and other providers of service may be paid directly when you assign benefits in writing. Hospital charges are generally paid directly to the hospital.

You must submit requests for payment within fifteen (15) months from the date services were provided or payment will be denied.

Each claim submission must contain the following:

Subscriber's name	Date(s) of service
Subscriber ID / Member number	Diagnosis
Group number	Type(s) of service
Patient's name	Provider's name & tax ID number
Patient's date of birth	Amount charged for each service
Patient's date of injury/illness or onset of illness or pregnancy	Patient's other insurance information
	For Members with Medicare — the Medicare ID number & the Medicare effective date

In addition, a copy of the provider's billing (showing the services rendered, dates of treatment, patient's name, relationship to the Plan Member, and provider's signature or ID number) must be included. Your PERSCare ID card has your member and group numbers on it.

See the inside front cover for information on obtaining and submitting claim forms.

LIABILITIES

Third-Party Liability

If a Plan Member alleges that he or she has been injured through the act or omission of another person (a "third party"), PERSCare shall, with respect to services required as a result of that injury, provide the benefits of the Plan only on the condition that the Plan Member:

1. reimburses PERSCare, to the extent of benefits provided, immediately upon collection of damages by him or her for such injury from any source, including any applicable automobile uninsured or underinsured motorist coverage, whether by action of law, settlement, or otherwise; and

2. provides PERSCare with a lien, to the extent of benefits provided by PERSCare, upon the Member's claim against or because of the third party. The lien may be filed with the third party, the third party's agent, the insurance company, or the court; and

3. consents to the release of all information, medical or otherwise, which may be relevant to the identification of and collection from parties responsible for the Member's illness or injury.

If the Plan Member receives from a third party the reasonable value of covered services rendered by a Preferred Provider, the Preferred Provider who rendered these services is not required to accept the amounts paid by PERSCare as payment in full, but may collect from the Member the difference, if any, between the amounts paid by PERSCare and the amount billed by the Preferred Provider for these services.

Plan Member Liability When Payment is Made by PERSCare

When covered services have been rendered by a Preferred Provider or Participating Pharmacy and payment has been made by PERSCare, the Plan Member is responsible only for any applicable deductible and/or copayment. However, if covered services are rendered by a non-Preferred Provider or a non-Participating Pharmacy, the Member is responsible for any amount PERSCare does not pay.

When a benefit specifies a maximum payment and the Plan's maximum has been paid, the Plan Member is responsible for any charges above the benefit maximum, regardless of the provider's status who renders the services.

In the Event of Insolvency

If PERSCare should become insolvent and no payment, or partial payment, is made for covered services, the Plan Member is responsible for any charges incurred, regardless of the provider's status who renders the services. Providers may bill the Plan Member directly, and the Member will have no recourse against the California Public Employees' Retirement System, its officers, or employees for reimbursement of his or her expenses.

LIABILITIES

Plan Liability for Provider Services

In no instance shall PERSCare, Blue Cross of California, or the contracted Blue Cross/Blue Shield plan be liable for negligence, wrongful acts or omissions of any person, physician, hospital or hospital employee providing services.

Maintenance of Preferred Provider Reimbursement Levels

If a Preferred Provider breaches or terminates its contract with Blue Cross of California or a Blue Cross/Blue Shield plan for Preferred Provider services, PERSCare may, based upon medical necessity, approve continuation of care at the Preferred Provider level of reimbursement. Upon PERSCare's approval, reimbursement shall be made at the Preferred Provider level of reimbursement and the balance will be the obligation of the Plan Member.

In the event that a Preferred Provider is unwilling or unable to provide continuing care to a Plan Member, then it shall be the responsibility of the Member to choose an alternative provider and to determine the Preferred Provider status of that provider.

GENERAL PROVISIONS

Eligibility

If you encounter any problems with eligibility, you should contact your employing agency's Health Benefits Officer (active) or the CalPERS Health Benefit Services Division (retirees) to resolve the problem. Once the problem has been corrected, CalPERS will notify Blue Cross.

Possible problems that require HBO intervention include:
- No record of enrollment;
- Dispute with regard to the effective date of coverage and cancellation dates;
- Changes in family status (i.e., marriage, divorce, and newborn and adopted children).

Coordination of Benefits

(Not Applicable to the Outpatient Prescription Drug Program)

Coordination of Benefits is designed to provide maximum coverage for medical and hospital bills at the lowest cost by avoiding excessive payments.

A questionnaire will be sent to you annually regarding other health care coverage or Medicare coverage. A questionnaire regarding third-party liability will be sent to you following Blue Cross' receipt of any claim which appears to be the liability or legal responsibility of a third party. Your cooperation in returning the form promptly will provide information necessary to process your claim. If another carrier has the primary responsibility for claims payment, please submit a copy of the Explanation of Benefits with the itemized bill from the provider of service. Your claim cannot be processed without this information.

A Plan Member who is also covered under another group plan (or plans) will not be permitted to make a "profit" by collecting benefits in excess of actual value or cost during any calendar year. Instead, payments will be coordinated between the plans to provide payment by each plan up to each plan's Allowable Amount.

Definitions

Allowable Expense — A charge for services or supplies which is considered payable in whole or in part under at least one of the plans covering the Plan Member.

Other Plan — Any blanket or franchise insurance coverage, group service plan contracts, group practice or any other prepayment coverage on a group basis or any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefit organization plans or Medicare.

Primary Carrier — A plan which has primary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions below.

Secondary Carrier — A plan which has secondary responsibility for the provision of benefits after the primary carrier determines its benefits according to the "Order of Benefit Determination" provisions below.

GENERAL PROVISIONS

Order of Benefit Determination

When the other plan does not have a Coordination of Benefits provision, it will always provide its benefits first. Otherwise, the order of benefit payments is determined by the following rules:

1. A plan which covers the Plan Member other than as a dependent shall have primary responsibility for the provision of benefits before a plan which covers the Plan Member as a dependent.

2. When a plan covers the Plan Member as a dependent child whose parents are not separated or divorced, and each spouse is covered by a group plan which covers the Plan Member as a dependent, the plan of the spouse whose date of birth (excluding year of birth) occurs earlier in the calendar year shall have primary responsibility for the provision of benefits. If either plan does not have the provisions of this paragraph regarding dependents, primary responsibility for the provision of benefits shall be determined by the plan which does not include these provisions.

3. When a claim involves expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent will determine their respective benefits in the following order: first, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

4. Regardless of (3) above, if there is a court decree that otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of that parent will determine its benefits before any other plan which covers the child as a dependent child.

5. If the above rules do not apply, the plan which has covered the Plan Member for the longer period of time will determine its benefits first, provided that:

    a. A plan covering a person as a laid-off or retired employee or as a dependent of that person will determine its benefits after any other plan covering that person as an employee other than a laid-off or retired employee, or such dependent; and

    b. If either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then paragraph (a) above will not apply.

Effect on Benefits

If this Plan is the primary carrier with respect to a Plan Member, then this Plan will provide its benefits without any reduction because of benefits available from any other plan. Physician Members and other Preferred Providers may collect any difference between their Billed Charges and this Plan's payment from the secondary carrier(s).

If this Plan is the secondary carrier with respect to a Plan Member, and Blue Cross of California or the Blue Cross/Blue Shield plan is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the benefits that would be due as if it were the primary plan, provided that the Plan Member (1) assigns the right to receive benefits from the other plan to the extent of the difference between the value of the benefits which are actually provided and the value of the benefits that Blue Cross of California or the Blue Cross/Blue Shield plan would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully in obtaining payment of benefits from the other plan, and (3) allows Blue Cross of California or the Blue Cross/Blue Shield plan to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

GENERAL PROVISIONS

Benefits for Medicare-Eligible Members

Members eligible for Medicare receive the full benefits of this Plan, except for those Members listed below:

1. End-stage Renal Disease — Members who are receiving treatment for end-stage renal disease following the first 30 months such Member is entitled to end-stage renal disease benefits under Medicare; and

2. Disabled Persons — Members who are entitled to Medicare benefits as disabled persons, unless such Member has a current employment status, as determined by Medicare rules, through an employer with 100 or more employees (according to OBRA legislation).

In cases where exceptions 1 or 2 apply, this Plan will be considered the secondary carrier and payment will be determined according to the provisions outlined under “Coordination of Benefits” on page 60.

GENERAL PROVISIONS

Continuation of Group Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation of group coverage is provided through federal legislation and allows an enrolled active or retired employee or his or her enrolled family members who lose their regular group coverage because of certain qualifying events to elect continuation of coverage for eighteen (18) or thirty-six (36) months.

An eligible active or retired employee or his or her family member(s) is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the required premium is paid. The benefits of the continuation of coverage are identical to the group Plan and the cost of coverage may not exceed one hundred and two percent (102%) of the applicable group premium rate, except for the employee who is eligible to continue group coverage to twenty-nine (29) months because of entitlement to Social Security disability benefits, in which case, the cost of coverage for months nineteen (19) through twenty-nine (29) shall not exceed one hundred and fifty percent (150%) of the applicable group premium rate. No employer contribution is available to cover the premium.

Qualifying Events

Two qualifying events allow employees to request the continuation of coverage for eighteen (18) months: (This coverage may be continued for up to twenty-nine (29) months for federally recognized disabled employees.)

1. the covered employee's separation from employment (other than by reason of gross misconduct);

2. reduction in the covered employee's hours to less than half-time (or a permanent intermittent employee not working the required hours during a control period).

The following qualifying events allow enrolled family member(s) to elect the continuation of coverage for up to thirty-six (36) months:

1. the employee's or retiree's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS);

2. the divorce or legal separation of the covered employee or retiree from the employee's or retiree's spouse;

3. the retiree's entitlement to benefits under Medicare;

4. a dependent child ceases to be a dependent child due to marriage or attainment of age twenty-three (23).

Effective Date of the Continuation of Coverage

If elected, COBRA continuation of coverage is effective on the date coverage under the group Plan terminates.

Termination of Continuation of Group Coverage

The continuation of coverage will remain in effect for the specified period of time, or until any one of the following events terminates the coverage:

1. termination of all employer-provided group health plans; or
2. the enrollee fails to pay the required premiums on a timely basis; or
3. the enrollee first becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation after electing COBRA; or

4. the enrollee first becomes entitled to Medicare benefits after electing COBRA; or

5. the continuation of coverage was extended to twenty-nine (29) months and there has been a final determination that the enrollee is no longer disabled; or

6. the Plan Member is terminated from the Plan for cause.

Notification of a Qualifying Event

You will receive notice from your employer of your eligibility for COBRA continuation of coverage if your employment is terminated or your number of work hours is reduced.

The employee, retiree, or affected family member is responsible for requesting information about COBRA continuation of coverage in the event of divorce, legal separation or a dependent child's loss of eligibility.

Contact your employing agency or CalPERS directly if you need more information about your eligibility for COBRA continuation of coverage.

Continuation of Group Coverage After COBRA

Certain former employees and their spouses (including a former spouse who is divorced from the former employee and a spouse who was married to the former employee at the time of that former employee's death) may be eligible to continue group coverage beyond the date their COBRA coverage ends. PERSCare will offer the extended coverage to former employees of employers that are subject to the existing COBRA, and to the former employees' divorced or widowed spouses if the divorced or widowed spouses are covered by COBRA pursuant to the terms of the qualifying events set forth below.

Qualifying Events

This coverage is subject to the following conditions:

1. The former employee worked for the employer for the prior five (5) years and was sixty (60) years of age or older on the date his or her employment ended; and

2. The former employee was eligible for and elected COBRA coverage for himself or herself or self and spouse.

Effective Date of the Continuation of Coverage

If elected, this coverage will begin after the COBRA coverage ends and will be administered under the same terms and conditions as if COBRA had remained in force.

Premiums

Premiums for this coverage may not exceed two hundred and thirteen percent (213%) of the applicable group premium rate. Payment is due at the time the employer's payment is due.

Notification Requirements

The employer is solely responsible for notifying former employees or former spouses (including a former spouse who is divorced from the former employee and a spouse who was married to the former employee at the time of that former employee's death) of the availability of the coverage at least ninety (90) calendar days before COBRA is scheduled to end. To elect this coverage, the former employee and/or former spouse must notify the Plan in writing at least thirty (30) days before COBRA is scheduled to end.

Termination of Continuation Coverage After COBRA

This coverage will end automatically on the earliest of the following dates:

1. the date the former employee, spouse, or former spouse reaches age sixty-five (65);

2. the date the employer ceases to maintain any group health plan;

3. the date the former employee, spouse, or former spouse is covered by another group health plan not maintained by the employer, whether or not the benefits of the other plan are less valuable than those of the plan maintained by the employer;

4. the date the former employee, spouse, or former spouse becomes eligible for Medicare;

5. for a spouse or former spouse, five (5) years from the date the former employee's employment with the employer ended.

Individual Conversion Plan

The Individual Conversion Plan will be available to a Plan Member whose continuation of group coverage is terminated or expires under the group continuation plan.

Continued Protection

Regardless of age, physical condition or employment status, you and your enrolled dependents may transfer to the Individual Conversion Plan then being issued by Blue Cross when enrollment is terminated, other than by voluntary cancellation or failure to continue enrollment or make contributions while in a non-pay status.

However, if this Plan is replaced by your employer with another plan, transfer to the Blue Cross conversion plan will not be permitted.

Applications for the conversion plan must be received by Blue Cross within thirty-one (31) days from the date coverage under PERSCare is terminated.

To request an application, write to:
Blue Cross of California
P.O. Box 9153
Oxnard, CA 93031-9153

Benefits and rates of individual conversion plans will be different from those of this Plan.

An individual conversion plan is also available to:

- Family members, if the employee or annuitant dies;
- Family members who marry or attain the age of twenty-three (23) while enrolled under PERSCare;
- Family members of an employee who enters military service; and
- The spouse of a Plan Member whose marriage has been terminated.

When a family member reaches age twenty-three (23), or if a family member becomes ineligible for any other reason given above, **it is your responsibility to inform Blue Cross**. Upon receiving notification, Blue Cross will offer such family member an individual conversion plan.

GENERAL PROVISIONS

Benefits After Termination

1. In the event the Plan is terminated by the Board or by PERSCare, PERSCare shall provide an extension of benefits for a Plan Member who is totally disabled at the time of such termination, subject to the following provisions:

   a. For the purpose of this benefit, a Plan Member is considered totally disabled when confined in a hospital or skilled nursing facility or confined pursuant to an alternative care arrangement when, as a result of accidental injury or disease, the Member is prevented from engaging in any occupation for compensation or profit or is prevented from performing substantially all regular and customary activities usual for a person of the Member's age and family status, or when diagnosed as totally disabled by the Member's physician and such diagnosis is accepted by PERSCare.

   b. The services and benefits under this Plan shall be furnished solely in connection with the condition causing such total disability and for no other condition not reasonably related to the condition causing the total disability, illness or injury. Services and benefits of this Plan shall be provided only when written certification of the total disability and the cause thereof has been furnished to Blue Cross by the Plan Member's physician within thirty (30) days from the date the coverage is terminated. Proof of continuation of the total disability must be furnished by the Member's physician not less frequently than at sixty (60) day intervals during the period that the termination services and benefits are available.

      Extension of coverage shall be provided for the shortest of the following periods:

      - Until total disability ceases;
      - For a maximum period of twelve (12) months after the date of termination, subject to PERSCare maximums; or
      - Until the Plan Member's enrollment under any replacement hospital or medical plan without limitation to the disabling condition.

2. If on the date a Plan Member's coverage terminates for reasons other than termination of the Plan by the Board or by PERSCare or voluntary cancellation, and the date of such termination of coverage occurs during the Member's certified confinement (in a hospital, skilled nursing facility or alternative care arrangement), the services and benefits of this Plan shall be furnished solely in connection with the conditions causing such confinement.

   Extension of coverage shall be provided for the shortest of the following periods:

   - For a maximum period of ninety-one (91) days after such termination; or
   - Until the Plan Member can be discharged from the hospital or skilled nursing facility as determined by PERSCare; or
   - Until the Plan's maximum benefits are paid.

Prudent Buyer Plan Provider Reimbursement

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating physician may, after notice from Blue Cross, be subject to a reduced negotiated amount in the event the participating physician fails to make routine referrals to Preferred Providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

GENERAL PROVISIONS

Continuity of Care

If Blue Cross of California (or a Blue Cross or Blue Shield Plan outside California) terminates its contractual relationship with a Preferred Provider and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination).

To qualify, you must have an acute condition or a serious chronic condition, a high-risk pregnancy, or a pregnancy that has reached the second or third trimester.

In cases involving an acute condition or a serious chronic condition, the Plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for up to 90 days, or a longer period if necessary for a safe transfer to another provider as determined by the Plan in consultation with the terminated provider, consistent with good professional practice. Coverage is provided according to the terms and conditions of this Plan applicable to Preferred Providers.

In the case of pregnancy, the Plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed, or a longer period if necessary for a safe transfer to another provider as determined by the Plan in consultation with the terminated provider, consistent with good professional practice. Coverage is provided according to the terms and conditions of this Plan applicable to Preferred Providers.

You may request this continuity of care by calling the Customer Service telephone number printed on your ID card.

MEDICAL CLAIMS APPEAL PROCEDURE

The procedures outlined below are designed to ensure the Plan Member full and fair consideration of complaints submitted to the Plan. The procedures should be followed carefully and in the order listed.

Claims for payment must be submitted to Blue Cross within ninety (90) days after the date of the medical service, if reasonably possible, but in no event, except for the absence of legal capacity, may claims be submitted later than fifteen (15) months from the date of service or payment will be denied.

The following procedures shall be used to resolve any dispute which results from any act, error, or omission with respect to any medical claim filed by or on behalf of a Plan Member. (See Utilization Review Appeal Procedure on pages 70 through 72 for procedures used to resolve any dispute which results from a medical necessity determination by Blue Cross' Review Center.)

The cost of copying and mailing medical records required for Blue Cross to review its determination is the responsibility of the person or entity requesting the review.

1. **Notice of Claim Denial**

   In the event any claim for benefits is denied, in whole or in part, Blue Cross shall notify the Plan Member of such denial in writing. The notice shall contain specific reasons for such denial and an explanation of the Plan's review and appeal procedure.

2. **Objection to Claim Processing or Denial**

   An aggrieved Plan Member may object by writing to Blue Cross' Customer Service Department within sixty (60) days of the discovery of any act, error, or omission with regard to a properly submitted claim; or within sixty (60) days of receipt of a notice of claim denial. The objection must set forth all reasons in support of the proposition that an act, error, or omission occurred.

3. **Time Limits for Response to Objection**

   Blue Cross will acknowledge receipt of a complaint by written notice to the Member within twenty (20) days. Blue Cross will then either affirm or resolve the denial within thirty (30) days. If the case involves an imminent threat to the Member's health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of the grievance will be expedited.

   If Blue Cross affirms the denial or fails to respond within thirty (30) days after receiving the request for review and the Member still objects to an act, error, or omission as stated above, the Member may proceed to item 4 below.

4. **Request for Reconsideration**

   If the Plan Member is not satisfied with the response to the initial inquiry, he or she may request reconsideration within sixty (60) days of receiving notice of Blue Cross' response. The request should be submitted in writing to the Customer Service Department. Any additional information that would affect the decision should be included. Blue Cross of California will acknowledge receipt of a reconsideration request by written notice to the Member within twenty (20) days. Blue Cross will then either affirm or resolve the denial within thirty (30) days.

5. **Request for Administrative Review**

   If the Plan Member is not satisfied with the response to the Request for Reconsideration, he or she may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on page 74.

MEDICAL CLAIMS APPEAL PROCEDURE

Objection to Denial of Experimental or Investigative Treatment

If services are denied because Blue Cross determines that they are experimental or investigational, an independent review may be requested. You may request an independent external review of a coverage decision for services that have been denied as being experimental or investigational if: (1) you have a terminal condition; (2) your physician certifies that standard therapies have been ineffective or would be inappropriate; and (3) either your physician certifies in writing that the denied therapy is likely to be more beneficial than standard therapies, or you or your physician have requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies. You will be notified of the opportunity to request this review when services are denied.

UTILIZATION REVIEW APPEAL PROCEDURE

Blue Cross' Review Center may render a determination on whether or not a particular medical service is medically necessary at any of the following three stages:

1. Before services are rendered (prospective utilization review—see page 41 for Precertification and page 42 for Non-Emergency Admissions); or

2. During the rendering of services (concurrent utilization review); or

3. After services are rendered (retrospective utilization review).

If a Plan Member, treating provider, or facility disagrees with the Review Center's determination at any of these stages, they have the right to state that disagreement and request a re-review by the Review Center. The Review Center may refer certain prospective review determinations directly to CalPERS for its final administrative determination.

The cost of copying and mailing medical records required for the Review Center to review its determination is the responsibility of the person or entity requesting the review.

Prospective and Concurrent Utilization Review Decisions

The following procedures apply to reviews of determinations made prior to or during the time medical services are rendered:

Step 1: Reconsiderations

If the Review Center does not certify a requested medical service, the Plan Member, treating provider, or facility may request a reconsideration review by a Review Center physician advisor. This request must be made within thirty (30) days of receipt of the initial notification of noncertification. This request may be made orally by calling 1-800-451-6780 or by a written request sent to:

Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

New information, if available, should be submitted with a request for reconsideration. This may include:

- Additional test results or other diagnostic or qualitative information not provided with the initial request;

- Information regarding additional health concerns or other special circumstances which can impact or affect treatment decisions;

- Information about how proposed treatment impacts or affects functional capabilities or medical stability; or

- Information about changes in health status.

The review will be handled in the following manner:

- After reviewing all medical information received, the Review Center physician will discuss the proposed or ongoing treatment with the treating physician by telephone.

- The physician advisor will inform the treating physician whether the noncertification will be overturned or upheld.

- Written confirmation of the decision will be issued to the Member and provider(s) within one (1) business day following the date the decision is made.

Step 2: Appeals

If the Review Center's noncertification is upheld following reconsideration review, the Plan Member, treating provider, or facility may request a second level of review, or Appeal, by a different physician advisor.

The Appeal process will follow the same procedures as in Step 1 above.

The Member, treating provider, or facility must request an Appeal within thirty (30) days of receipt of the reconsideration determination. This request may be initiated orally but must be immediately followed by a written request sent to the above address.

New information, if available and not submitted at the time the reconsideration was requested, should be submitted with a request for Appeal.

All relevant new information, examples of which are provided in Step 1 above, must be received no later than sixty (60) days after the initiation of the Appeal to be considered by the Review Center.

Retrospective Utilization Review Decisions

The following procedures apply to reviews of determinations made after services have been rendered:

Step 1: Reconsiderations

If the Review Center has not approved a request for a medical service that has already been received, the Plan Member, treating provider, or facility may request a reconsideration review by a Review Center physician advisor. This request for review must be made within thirty (30) days after receiving the noncertification and submitted in writing to:

Blue Cross of California
P.O. Box 4386
Woodland Hills, CA 91365-4386

New information, if available, should be submitted with a request for reconsideration. This may include:

- Additional test results or other diagnostic or qualitative information not provided with the initial request;

- Information regarding additional health concerns or other special circumstances which can impact or affect treatment decisions;

- Information about how the treatment impacts or affects functional capabilities or medical stability; or

- Information about changes in health status.

UTILIZATION REVIEW APPEAL PROCEDURE

The review will be handled in the following manner:

- After reviewing all medical records received, a Review Center physician advisor will review the case and make a determination.
- Written confirmation of the decision will be issued to the Member and provider(s) within one (1) business day following the date the decision is made.

Step 2: Appeals

If the Review Center's noncertification is upheld following reconsideration review, the Plan Member, treating provider, or facility may request a second-level review, or Appeal, by a different physician advisor.

The Plan Member, treating provider, or facility may only request an Appeal within thirty (30) days of receipt of the reconsideration determination. This request must be submitted in writing to the same address as in Step 1 above.

New information, if available and not submitted at the time the reconsideration was requested, should be submitted with a request for Appeal.

All relevant new information, examples of which are provided in Step 1 above, must be received no later than sixty (60) days after the initiation of the Appeal to be considered by the Review Center.

The review will be handled in the following manner:

- A different Review Center physician advisor will review the medical records received, with any additional information that may be submitted, and make a determination.
- Written confirmation of the decision will be issued to the Member and provider(s) within thirty 30 days of receipt of any additional medical records that may be required.

Request for Administrative Review

Following a prospective, concurrent, or retrospective noncertification, if the Plan Member or the Plan Member's provider continues to contest the Review Center's determination after pursuing the matter through the Review Center's Appeal procedure, the Plan Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure found on page 74 of this booklet.

Objection to Denial of Experimental or Investigative Treatment

If services are denied because the Blue Cross Review Center determines that they are experimental or Investigational, an independent external review may be requested. You may request an independent review of a coverage decision for services that have been denied as being experimental or investigational if:

- You have a terminal condition;
- Your physician certifies that standard therapies have been ineffective or would be inappropriate; and
- Either your physician certifies in writing that the denied therapy is likely to be more beneficial than standard therapies, or you or your physician have requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies.

You will be notified of the opportunity to request this review when services are denied.

PRESCRIPTION DRUG APPEAL PROCEDURE

1. Denial of Payment for an Excluded Drug

When payment is denied because of a drug exclusion, the Plan Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on page 74.

2. Denial of a Drug Requiring Approval Through Prior Authorization

Appeals related to Prior Authorization requirements must be directed to:

Merck-Medco Managed Care, L.L.C.
700 West Third Avenue
Columbus, OH 43212
Attention: Managed Prior Authorization

If the Plan Member is dissatisfied with the determination made by Merck-Medco, the member may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on page 74.

3. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for prescription drugs are not payable when first submitted to Merck-Medco (see page 46). If Merck-Medco, through its PAID Prescriptions and Merck-Medco Rx Services subsidiaries, determines that a claim is not payable, a claim rejection letter will be mailed to the Plan Member explaining the reason(s) for nonpayment.

Appeals concerning direct reimbursement claims must be directed to:

PAID Prescriptions, L.L.C.
399 Jefferson Road
Parsippany, NJ 07054

If the Plan Member is dissatisfied with the determination made by PAID Prescriptions, the Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure described on page 74.

Before rejecting a claim, Merck-Medco may, at its discretion, initiate its own review to determine if the claim can be paid. If the claim has erroneous or missing data that may be needed to properly process the claim, the Member may be asked to resubmit the claim.

If after resubmission the claim is determined to be payable in whole or in part, Merck-Medco will take whatever action necessary to pay the claim according to established procedures.

If the claim is still determined to be not payable in whole or in part after resubmission, Merck-Medco will inform the Plan Member in writing of the reason(s) for denial of the claim and advise the Member of his or her appeal rights as described in this section.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

If the Plan Member remains dissatisfied after the appeal procedures of the appropriate third-party administrator have been exhausted, the Member may appeal to CalPERS. This appeal must be submitted in writing to CalPERS within thirty (30) days from the postmark date of the administrator's final determination.

The appeal must be mailed to:

CalPERS Health Benefit Services Division
Appeals Coordinator — PERSCare Health Plan
P.O. Box 942714
Sacramento, CA 94229-2714

The appeal must set forth the facts and the law upon which the appeal is based. The time limit may be extended an additional thirty (30) days if good cause is shown; however, in no event will an appeal be accepted more than sixty (60) days after the postmark date of the Plan's final administrative determination.

Examples of what may be appealed include, but are not limited to:
- Failure to properly pay incurred expenses.
- Denial of approval for covered services.

Examples of what may not be appealed include, but are not limited to:
- Medical malpractice.
- Reimbursement at levels specified in the Evidence of Coverage.

If CalPERS refuses to accept the appeal, the Member's option is to proceed directly to court.

If CalPERS accepts the appeal, the following procedures apply.

1. Administrative Review

The Plan Member may express his or her concern(s) by presenting information or arguments in writing to support his or her position. CalPERS staff will attempt to resolve or address the Member's concern(s) in writing within thirty (30) days from the date the Member presents his or her concern(s).

2. Administrative Hearing

If the dispute remains unresolved following the Administrative Review process, the matter will proceed through the administrative hearing process. These hearings are conducted in accordance with the Administrative Procedure Act (Government Code Section 11500 et seq.). Plan Members unrepresented by an attorney should become familiar with this law and its requirements if they choose to appeal to this level.

3. Procedures Before the CalPERS Board

After the administrative hearing, the Administrative Law Judge (ALJ) will issue a proposed decision which the CalPERS Board of Administration must adopt before it can take effect. The Board may either:

a. Adopt the ALJ's proposed decision; or
b. Reconsider the decision.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

4. Appeal Beyond Administrative Process

Upon exhaustion of the appeal process outlined above, if a Member is still dissatisfied with the outcome, he or she may appeal to the courts.

Civil legal remedies may not be commenced until you have complied with these administrative procedures.

Summary of Process and Rights of Plan Members

- **Right to records, generally.** The Plan Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Right to an attorney.** At any stage of the appeal proceedings, the Plan Member has a right to be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney.
- **Right to experts and consultants.** At any stage of the proceedings, the Plan Member has a right to present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense.

Service of Legal Process

Legal process or service upon the Plan must be served at:

CalPERS Legal Office
Lincoln Plaza
400 "P" Street, Room 3340
Sacramento, CA 95814

MONTHLY RATES

Type of Enrollment	Enrollment Code	Cost
Insured Only	2781	$361
Insured and One Dependent	2782	$722
Insured and Two or More Dependents	2783	$939

State Employees and Annuitants. The rates shown above are effective February 1, 2001, and will be reduced by the amount the State of California contributes toward the cost of your health benefits plan. These contribution amounts are subject to change by legislative action. Any such change will be accomplished by the State Controller or affected retirement system without action on your part. For current contract information, contact your employing agency's or retirement system's Health Benefits Officer.

Public Agency Employees and Annuitants. The rates shown above are effective February 1, 2001, and will be reduced by the amount your public agency contributes toward the cost of your health benefits plan. This amount varies among public agencies. For assistance in calculating your net cost, contact your employing agency's or your retirement system's Health Benefits Officer.

Rate Change. The plan rates may change as of January 1, 2002, following at least sixty (60) days' written notice to the California PERS Board of Administration prior to such change.

DEFINITIONS

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

Act — the Public Employees' Medical and Hospital Care Act (Part 5, Division 5, Title 2 of the Government Code of the State of California).

Acute Condition/Care — care provided in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and not expected to last indefinitely.

Administrator —

1. denotes CalPERS as the global administrator of the Plan through the Self-Funded Health Plans Unit of the Self-Funded Programs Division of CalPERS, also referred to as "the Plan"; and

2. denotes entities under contract with CalPERS to administer the Plan, also known as "third-party administrators" or "administrative service organizations."

Allowable Amount — the Blue Cross of California (applying to Members residing in California or out-of-area) or the local Blue Cross/Blue Shield plan (applying to Members outside California) allowance or negotiated amount as defined below for the service(s) rendered, or the provider's Billed Charge, whichever is less. The Allowance is:

1. the amount that Blue Cross of California or the local Blue Cross/Blue Shield plan has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based on such factors as the Plan's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or

2. such other amount as the Preferred Provider and Blue Cross of California or the local Blue Cross/Blue Shield plan have agreed will be accepted as payment for the service(s) rendered; or

3. if an amount is not determined as described in either (1) or (2) above, the amount that Blue Cross of California or the local Blue Cross/Blue Shield plan determines is appropriate considering the particular circumstances and the services rendered.

Alternative Birthing Center —

1. a birthing room located physically within a hospital to provide homelike outpatient maternity facilities, or

2. a separate birthing center that is certified or approved by a state department of health or other state authority and operated primarily for the purpose of childbirth.

Ambulatory Surgery Center — any public or private establishment with an organized medical staff of physicians; permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; continuous physician services whenever a patient is in the facility; and which does not provide services or accommodations for patients to stay overnight.

Annuitant — is defined in accordance with the definition currently in effect in the Act and Regulations.

Appeal — refers to the Member's right to request review of decisions relating to the Member's rights under the Plan. The term includes all of the following: the internal review by Blue Cross and Merck-Medco Managed Care, L.L.C., sometimes referred to as a Plan grievance procedure; the Plan's final administrative review by CalPERS; the fair hearing accorded by statute; and any administrative and judicial review thereof.

DEFINITIONS

Balance Billing — a request for payment by a provider to a Member for the difference between Blue Cross of California or Blue Cross/Blue Shield Allowable Amounts and the Billed Charges.

Billed Charges — the amount the provider actually charges for services provided to a Member.

Blue Cross — the claims administrator responsible for administering medical benefits and providing utilization review services under this Plan. As used in this Evidence of Coverage booklet, the term "Blue Cross" shall be used to refer to both Blue Cross of California and BC Life & Health Insurance Company. Blue Cross, as defined, is a separate and distinct entity from references to the Blue Cross and Blue Shield Association or Blue Cross and/or Blue Shield plan providers.

Board — the Board of Administration of the California Public Employees' Retirement System (CalPERS).

Centers of Expertise (COE) — health care providers that have a Centers of Expertise (COE) Agreement in effect with Blue Cross at the time services are rendered. COEs agree to accept the COE Negotiated Amount as payment in full for covered services. A Preferred Provider in the Prudent Buyer Plan Network is not necessarily a COE. A provider's participation in the Prudent Buyer Plan Network or other agreement with Blue Cross is not a substitute for a Centers of Expertise Agreement.

Centers of Expertise (COE) Negotiated Amount — the fee Centers of Expertise agree to accept as payment in full for covered services. It is usually lower than their normal charge. COE negotiated amounts are determined by Centers of Expertise Agreements.

Chiropractic Services — chiropractic services billed by any licensed physician will apply toward the chiropractic benefit plan year maximum.

Christian Science Hospital — only nursing homes and sanitariums which are approved by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Christian Science Nurses — only those Christian Science nurses approved as such by The First Church of Christ Scientist, in Boston, Massachusetts.

Christian Science Practitioners — only those Christian Science practitioners approved as such by the Board of Directors, The First Church of Christ Scientist, in Boston, Massachusetts, and listed in the Christian Science Journal.

Chronic Care — treatment for an illness, injury or condition which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration, has no reasonably predictable date of termination, and may be marked by recurrence requiring continuous or periodic care as necessary.

Close Relative — the spouse, child, brother, sister or parent of a subscriber or family member.

Contract Period — the period of time from February 1, 2001, through December 31, 2001, during which benefits and benefit levels remain unchanged by the Plan.

Cosmetic Procedure — any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

DEFINITIONS

Custodial Care — care provided either in the home or in a facility primarily for the maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of illness or accidental injury. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding (including the use of some feeding tubes not requiring skilled supervision), preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Disability — an injury, an illness (including any mental disorder), or a condition (including pregnancy); however,

1. all injuries sustained in any one accident will be considered one disability;

2. all illnesses existing simultaneously which are due to the same or related causes will be considered one disability;

3. if any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous disability and not a separate disability.

Drugs and Medicines — those lawfully obtainable only on the prescription of a physician; the generic formulas which are approved by the Food and Drug Administration; but does not mean (1) appliances, devices, bandages, heat lamps, braces, splints, and artificial appliances; (2) health and beauty aids, cosmetics, and dietary supplements, except as specifically provided; or (3) such other drugs or items which are set forth as exclusions.

Durable Medical Equipment (Prosthetic Appliances and Home Medical Equipment) — see definition under Home Medical Equipment.

Elective (Non-emergency) Services — services provided when the patient's condition permits adequate time to schedule the necessary diagnostic work-up and/or initiation of treatment.

Emergency Care Services — those services required for alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen medical or psychiatric condition which if not immediately diagnosed and treated could lead to further disability or death, or which would so appear to a prudent layperson.

Employee — is defined in accordance with the definition currently in effect in the Act and Regulations.

Employer — is defined in accordance with the definition currently in effect in the Act and Regulations.

Experimental or Investigational — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury, or condition at issue. Services which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered, shall be considered experimental or investigational. Services which themselves are not approved or recognized as being in accord with accepted professional medical standards, but nevertheless are authorized by law or a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational. Any issue as to whether a protocol, procedure, practice, medical theory, or treatment is experimental or investigational will be resolved by Blue Cross, which will have full discretion to make such determination on behalf of the Plan and its participants.

DEFINITIONS

Family Member — an employee's or annuitant's lawful spouse and any unmarried child under age twenty-three (23), including an adopted child, a stepchild, or recognized natural child who lives with the employee or annuitant in a regular parent-child relationship. It also includes an unmarried child under age twenty-three (23) who is economically dependent upon the employee or annuitant while there exists a parent-child relationship, or is dependent upon the employee or annuitant for medical support by reason of a court order. It also includes an unmarried child age twenty-three (23) or over who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age twenty-three (23).

FDA — Food and Drug Administration.

Formulary — a listing of drugs in major therapeutic categories, selected by an independent committee of medical and pharmacy professionals who are either physicians or clinical pharmacists with a doctorate in pharmacology (Pharm D), and which are considered to be preferred over other drug alternatives. Formulary drugs are evaluated for: (1) indications; (2) side effects; (3) interaction with other drugs; (4) dosage form availability; (5) pharmacokinetics (how a drug is absorbed, distributed, metabolized and excreted); and (6) physician preference. The objective of the formulary is to improve the quality of patient care by promoting high quality, cost-effective prescribing and dispensing of prescription drugs.

Health Professional — dentist; optometrist; podiatrist or chiropodist; clinical psychologist; chiropractor; acupuncturist; clinical social worker; marriage, family and child counselor; physical therapist; speech pathologist; audiologist; licensed occupational therapist; physician assistant; registered nurse; registered dietitian for the provision of diabetic medical nutrition therapy only; a nurse practitioner and/or nurse midwife providing services within the scope of practice as defined by the appropriate clinical license and/or regulatory board.

Homebound — Members are considered to be "homebound" if they have a condition due to an illness or injury that restricts their ability to leave their place of residence.

Home Health Agencies and Visiting Nurse Associations — home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home and recognized as home health providers under Medicare.

Home Health Aide — (In California) an aide who has successfully completed a training program approved by the California Department of Health Services pursuant to applicable federal and state regulation, is employed by a home health agency or hospice program, provides personal care services in the patient's home, and is certified pursuant to Section 1736.1 of the Health and Safety Code. (Outside California) an aide who has successfully completed a state-established or other training program that meets certain federal requirements.

Home Infusion Therapy — refers to a course of treatment whereby a liquid substance is introduced into the body for therapeutic purposes. The infusion is done in the home at a continuous or intermittent rate.

Home Infusion Therapy Provider — a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Home Medical Equipment (Durable Medical Equipment) — equipment designed for repeated use which is determined to be medically necessary to treat an illness, injury or condition; to improve the functioning of a malformed body part; or to prevent further deterioration of the patient's medical condition. Home medical equipment includes items such as wheelchairs, hospital beds, respirators, and other items that the Plan determines are home medical equipment.

DEFINITIONS

Hospice Care — care received under a program that is: (1) designed to provide palliative and supportive care to individuals who have received a diagnosis of terminal illness; (2) supportive to the covered family members by providing certain services; (3) licensed or certified in the jurisdiction where the program is established; (4) directed and coordinated by medical professionals; and (5) approved by the Plan.

Hospital —

1. a licensed facility which is primarily engaged in providing, for compensation, medical, diagnostic and surgical facilities for the care and treatment of ill and injured persons on an inpatient basis, and which provides such facilities under the supervision of a staff of physicians and 24-hour-a-day nursing service by registered nurses. An institution which is principally a rest home, nursing home or home for the aged is not included; or

2. a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

3. a facility operated primarily for the treatment of chemical dependency and accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

4. a psychiatric health facility as defined in Section 1250.2 of the Health and Safety Code.

Incentive Formulary Program — Members may receive any covered drug with copayment differentials between generic, formulary, and non-formulary drugs.

Incurred Charge — a charge shall be deemed “incurred” on the date the particular service or supply is provided or obtained.

Infusion Center — Any location, licensed according to state and local laws, in which medically necessary intravenous prescription drugs are administered.

Inpatient — an individual who has been admitted to a hospital as a registered acute bed patient (overnight) and who is receiving services which could not be provided on an outpatient basis, under the direction of a physician.

Mandible — lower jawbone.

Masticatory Musculature — muscles involved in chewing.

Maxilla — upper jawbone.

Maxillomandibular — pertaining to the maxilla and mandible.

Medically Necessary — see the Medical Necessity provision on page 14.

Medicare — refers to the programs of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Member — see Plan Member.

Negotiated Amount — the amount agreed upon between Blue Cross of California or the local Blue Cross/Blue Shield plan and the Preferred Hospitals they have contracted with to provide medically necessary contractual benefits as described in this Evidence of Coverage booklet.

Non-Participating Pharmacy — a pharmacy which is not under a valid agreement with PAID Prescriptions, L.L.C., to provide prescription drug services to Plan Members.

DEFINITIONS

Non-Preferred Provider (Non-PPO) — a group of physicians, hospitals or other health professionals that (1) do not have a Prudent Buyer Plan Participating Provider Agreement in effect with Blue Cross of California at the time services are rendered, or (2) do not participate in a Blue Cross and/or Blue Shield plan network outside California at the time services are rendered. Any of the following types of providers may be non-PPO Providers: physicians, hospitals, ambulatory surgery centers, home health agencies or visiting nurse associations, facilities providing diagnostic imaging services, durable medical equipment providers, skilled nursing facilities, clinical laboratories, and home infusion therapy providers.

Occupational Therapy — treatment under the direction of a physician and provided by a licensed occupational therapist utilizing arts, crafts or specific training in daily living skills to improve and maintain a patient's ability to function.

Open Enrollment Period — a period of time established by the CalPERS Board of Administration during which eligible employees and annuitants may enroll in a health benefits plan, add family members, or change their enrollment from one health benefits plan to another without any additional requirements.

Other Providers — providers that are not represented in the Prudent Buyer Plan Network in California or in a Blue Cross and/or Blue Shield network of Preferred Providers outside California. In California, contact Blue Cross of California for information regarding which providers are represented in the Prudent Buyer Plan Network. Outside California, call 1-800-810-BLUE (1-800-810-2583) for information regarding which providers are represented in a Blue Cross and/or Blue Shield network outside California.

Out-of-Area — see page 10.

Outpatient — an individual receiving services under the direction of a physician but not incurring overnight charges at the facility where services are provided.

Outpatient Facility — a licensed facility, other than a physician's office or hospital, that provides medical and/or surgical services on an outpatient basis.

PAID's Allowable Amount — the amount that a Participating Pharmacy and PAID Prescriptions, L.L.C., have agreed will be accepted as payment for the prescription dispensed.

Participating Pharmacy — a pharmacy which is under a valid agreement with PAID Prescriptions, L.L.C., to provide prescription drug services to Plan Members.

Pharmacy — a licensed establishment where prescription drugs are dispensed by a pharmacist licensed under the laws of the state where such pharmacist practices.

Physical Therapy — treatment under the direction of a physician and provided by a licensed physical therapist or occupational therapist utilizing physical agents, such as ultrasound, heat and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

DEFINITIONS

Physician Member — a licensed physician who has contracted with Blue Cross of California to furnish services and to accept Blue Cross of California's payment, plus applicable deductibles and copayments, as payment in full for covered services.

Plan — means PERSCare. PERSCare is a self-funded health plan established and administered by CalPERS (the plan administrator and insurer) through contracts with third-party administrators: Blue Cross and Merck-Medco Managed Care, L.L.C. (a.k.a. PAID Prescriptions, L.L.C., or Merck-Medco Rx Services).

Plan Member — any employee, annuitant or family member enrolled in PERSCare.

Plan Year — an eleven (11) month period starting February 1, 2001 at 12:01 a.m. Pacific Standard Time and ending at 12 midnight PST on December 31, 2001.

Plastic Surgery — surgery to correct congenital or developmental abnormalities or characteristics which are outside the broad range of normal.

Precertification — the Plan's requirement for advance authorization of certain services to assess the medical necessity, efficiency and/or appropriateness of health care services or treatment plans. These services will be covered only on a case-by-case basis as determined by the Plan. This term does not include the determination of eligibility for coverage or the payment of benefits under the Plan.

Preferred Hospital — a hospital under contract with Blue Cross of California or a Blue Cross/Blue Shield plan which has agreed to furnish services and to accept Blue Cross of California's payment or the local Blue Cross/Blue Shield plan's payment, plus applicable deductibles and copayments, as payment in full for covered services.

Preferred Provider — a group of physicians, hospitals or other health professionals that (1) have a Prudent Buyer Plan Participating Provider Agreement in effect with Blue Cross of California at the time services are rendered, or (2) participate in a Blue Cross and/or Blue Shield plan network outside California at the time services are rendered. Any of the following types of providers may be PPO Providers: physicians, hospitals, ambulatory surgery centers, home health agencies or visiting nurse associations, facilities providing diagnostic imaging services, durable medical equipment providers, skilled nursing facilities, clinical laboratories and home infusion therapy providers.

Prescription Drugs — (1) all drugs which under federal or state law require the written prescription of a physician, dentist, podiatrist or osteopath; (2) insulin; (3) hypodermic needles and syringes if prescribed by a physician for use with a covered drug; (4) glucose test strips; and (5) such other drugs and items, if any, not set forth as an exclusion.

Prescription Legend Drug — any medicinal substance, the label of which is required, under the Federal Food, Drug and Cosmetic Act, to bear the legend "Caution: Federal laws prohibit dispensing without a prescription."

Prescription Order — the request for each separate drug or medication by a physician and each authorized refill of such request.

Prosthesis (or Prostheses) — the replacement of a missing body part or an organ by an artificial substitute.

Psychiatric Care — psychoanalysis, psychotherapy, counseling or other care most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage, family and child counselor to treat a nervous or mental disorder, or to treat mental or emotional problems associated with illness or injury.

DEFINITIONS

Reasonable charge — a charge Blue Cross considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Reconstructive Surgery — surgery to correct deformities resulting from injury or disease, or surgery which is medically necessary following injury or disease to restore an individual to normal.

Regulations — the Public Employees' Medical and Hospital Care Act Regulations as adopted by the CalPERS Board of Administration and set forth in Subchapter 3, Chapter 2, Division 1, Title 2 of the California Code of Regulations.

Rehabilitation or Rehabilitative Care — care furnished primarily to restore an individual's ability to function as normally as possible after a disabling disease, illness, injury or addiction. Rehabilitation or rehabilitative care services consist of the combined use of medical, social, educational, occupational/vocational treatment modalities and are provided with the expectation that the patient has restorative potential and will realize significant improvement in a reasonable length of time. Benefits for services for rehabilitation or rehabilitative care are limited to those specified under Precertification (see page 41).

Respite Care — continuous care of the patient in the most appropriate setting for the primary purpose of providing temporary relief to the family from the duties of caring for the patient.

Services — includes medically necessary health care services and medically necessary supplies furnished incident to those services.

Skilled Care — skilled supervision and management of a complicated or extensive plan of care for a patient instituted and monitored by a physician, in which there is a significantly high probability, as opposed to a possibility, that complications would arise without the skilled supervision or implementation of the treatment program by a licensed nurse or therapist.

Skilled Nursing Facility — a facility which is:

1. licensed to operate in accordance with state and local laws pertaining to institutions identified as such;

2. listed as a skilled nursing facility by the American Hospital Association and accredited by the Joint Commission on Accreditation of Healthcare Organizations and related facilities; or

3. recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States Government pursuant to the Medicare Act.

Speech Therapy — treatment under the direction of a physician and provided by a licensed speech pathologist or speech therapist to improve or retrain a patient's vocal skills which have been impaired by illness or injury.

Standard Wheelchair — a fixed-arm wheelchair, with swing-away foot rests, that does not include any additional attachments and is not motorized, customized or considered lightweight.

Subscriber — the person enrolled who is responsible for payment of premiums to PERSCare, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan.

Take-Home Prescription Drugs — prescription drugs which are dispensed prior to discharge from an inpatient setting.

Temporomandibular Joint (TMJ) — the joint that connects the lower jaw (mandible) to the skull.

DEFINITIONS

Temporomandibular Disorder (TMD) — a collective term embracing a number of clinical problems that involve the masticatory muscles, the temporomandibular joint, or both. Common patient complaints include jawache, headache, earache, and facial pain; and there may be associated limited or asymmetric jaw movement and joint sounds.

Terminal Illness — an illness in which it is reasonably certain that the patient has less than six (6) months to live. The patient's treating physician must provide written certification that the patient is terminally ill.

Total Disability —

1. with respect to an employee or person otherwise eligible for coverage as an employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage;

2. with respect to an annuitant or a family member, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage.

Treatment in Absentia — Christian Science practitioners or nurses rendering services, such as consultation or prayer via the telephone.

Treatment Plan — services or a plan of treatment preauthorized by the Plan during a contract period that must be commenced during the same contract period. To qualify for continuing treatment in a subsequent contract period, the services or plan of treatment must be reauthorized. Otherwise, only the benefits in effect during a contract period are available or covered.

United States – in regard to services available through the BlueCard network, the United States is defined as all the states and the District of Columbia.

Preventive Care Guidelines for Healthy Children, Adolescents, Adults, and Seniors

These guidelines are for information only and may be subject to change. Additionally, your Preferred Provider may modify these guidelines based on your health and history or individual risk factors. Please talk to your medical professional carefully about individual risk factors when making decisions about diagnostic tests.

These guidelines were adapted from the U.S. Preventive Services Task Force *Guide to Clinical Preventive Services* (2nd edition). Immunizations for infants and children are recommended in accordance with recommendations of the American Academy of Pediatrics and the American Academy of Family Physicians.

Children: Birth to 10 years

Health Screens	**Frequency**
Height & Weight	Annually and/or as recommended by your physician.
Blood Pressure	Annually and/or as recommended by your physician.
Hemoglobin/Hematocrit	Once between age 6 months and 2 years.
Test for thyroid activity, galactose metabolism disorder, hemoglobin (blood) disorder, phenylketonuria level (PKU), vision impairment	After birth, prior to hospital discharge but no later than 6th day of life. Thyroid activity screening can be done after birth, optimally at 2–6 days.
Hepatitis C Screening	Discuss with your physician.
Immunizations	**Frequency**
Diptheria, Tetanus, and Pertussis (DTaP or DTP)	Five doses: age 2, 4, 6, 15–18 months, and 4–6 years.
Polio Vaccine	Four doses: age 2, 4, 12–18 months, and 4–6 years.
Measles, Mumps, & Rubella (MMR)	Two doses: age 12-15 months, and either 4–6 years or 11–12 years.
Influenzae Type B (Hib)	Four doses: age 2, 4, 6, and 12–15 months.
Hepatitis B Vaccine. Those who have not previously received three doses of hepatitis B vaccine should initiate or complete the series at age 11–12 years.	Three doses: at birth–age 2 months (preferably prior to hospital discharge); 1–4 months; and 6–18 months.
Chickenpox (varicella virus)	Age 12–18 months. Children who lack a reliable history of chickenpox should be vaccinated at 11–12 years of age.

Preventive Care Guidelines for Healthy Children, Adolescents, Adults, and Seniors

Adolescents: **Ages 11–24 years**

Health Screens	**Frequency**
Height & Weight	Annually and/or as recommended by your physician.
Blood Pressure	Annually and/or as recommended by your physician.
Papanicolaou (Pap test for women)	Every 1–3 years (beginning at the onset of sexual intercourse).
Chlamydia Test	Recommended for sexually active female adolescents under age 20 and in other women with risk factors for infection. Screening sexually active young men may be recommended by your physician.
Hepatitis C Screening	Discuss with your physician.
Rubella susceptibility by history of vaccination or serologic tests for antibodies	Recommended for all women of childbearing age.
Immunizations	**Frequency**
Tetanus Booster	Either at age 11–12 years or 14–16 years.
Hepatitis B Vaccine	Those who have not previously received three doses of hepatitis B vaccine should initiate or complete the series at age 11-12 years.
Measles, Mumps, & Rubella (MMR)	At age 11–12 years if no previous second dose of MMR was received.
Chickenpox (varicella virus)	Unvaccinated persons who lack a reliable history of chickenpox should be vaccinated at age 11–12 years. Persons age 13 years and older should receive two doses at least one month apart.
Rubella Vaccine	Females over age 12 years who are rubella susceptible.
Lyme Disease Vaccine	For persons over age 15 with a high risk of contracting Lyme disease.

Preventive Care Guidelines for Healthy Children, Adolescents, Adults, and Seniors

Adults: Ages 25–64 years

Health Screens	Frequency
Height & Weight	Annually and/or as recommended by your physician.
Blood Pressure	Annually and/or as recommended by your physician.
Total Blood Cholesterol	Periodic screenings are recommended for men ages 35–65 years; women ages 45–65 years.
Papanicolaou (Pap test for women)	At least every 1–3 years.
Prostate Cancer Screening (PSA test for men)	Discuss PSA screening with your physician.
Colorectal Cancer Screening: fecal occult blood test and/or sigmoidoscopy or colonoscopy	Beginning at age 50. Discuss frequency and method with your physician.
Mammogram & Breast Examination	Breast examination recommended annually by your physician and monthly as self-examination.
Hepatitis C Screening	Discuss with your physician.
Screening for rubella susceptibility by history of vaccination or serologic tests for antibodies	Recommended for all women of childbearing age.
Sexually Transmitted Diseases	Recommended for all sexually active individuals.
Bone Densitometry	Discuss bone mass measurement with your physician.
Immunizations and HRT	**Frequency**
Tetanus Booster	Once every 10 years; 15–30 year intervals for adults who received a five-dose childhood series.
Rubella Vaccine	Recommended for all women of childbearing age if rubella susceptible.
Hormone Replacement Therapy (HRT)	Pre- and postmenopausal women should discuss benefits and risks with their physician.
Lyme Disease Vaccine	For persons with a high risk of contracting Lyme disease.

Preventive Care Guidelines for Healthy Children, Adolescents, Adults, and Seniors

Seniors: Age 65 and older

Health Screens	**Frequency**
Height & Weight	Annually and/or as recommended by your physician.
Blood Pressure	Annually and/or as recommended by your physician.
Total Blood Cholesterol	Screening may be considered on a case-by-case basis. Discuss with your physician.
Papanicolaou (Pap test for women)	At least every 1–3 years.
Prostate Cancer Screening (PSA test for men)	Discuss PSA screening with your physician.
Colorectal Cancer Screening: fecal occult blood test and/or sigmoidoscopy or colonoscopy	Discuss frequency and method with your physician
Mammogram & Breast Examination	Breast examination recommended annually by your physician and monthly as self-examination.
Hepatitis C Screening	Discuss with your physician.
Visual Acuity	Screening for medical eye conditions which may need further evaluations by an eye specialist (eye refractions in preparation for glasses not included).
Hearing Impairment	Periodic screening. Discuss with your physician.
Bone Densitometry	Discuss bone mass measurement with your physician.
Immunizations and HRT	**Frequency**
Tetanus Booster	Once every 10 years; at 15–30-year intervals for adults who received a five-dose childhood series.
Pneumococcal Vaccine	Once after age 65.
Influenza (flu) Vaccine	Annually beginning at age 65. Individuals at high risk should discuss with their physician.
Hepatitis B Vaccine	Discuss your risk with your physician.
Hormone Replacement Therapy (HRT)	Pre- and postmenopausal women should discuss benefits and risks with their physician.
Lyme Disease Vaccine	For persons with a high risk of contracting Lyme disease.

FOR YOUR INFORMATION

Organ Donation

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

Long-Term Care Program

Your PERSCare health plan has strict limits on the long-term care services it provides. The Long-Term Care Program offered by CalPERS provides coverage for the extended care you could need due to a chronic disease, frailty of old age, or serious accident. It covers help with activities of daily living, such as bathing eating and dressing. It also provides supervision and support for people with cognitive impairments such as Alzheimer's disease. Long-term care can be needed at any age.

The CalPERS Long-Term Care Program is not part of the PERSCare health plan. If you want long-term care protection, you must purchase it separately. Please contact the CalPERS Long-Term Care Program at 1-800-338-2244 if you are interested in long-term care coverage.

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